

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. **198**

Primary Registration District No. **3011**

Registrar's No. **79**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Clay**
(b) City or town **Excelsior Springs**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **21**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME **Mary Ellen Moore 600**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Charles** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Mar 12 1969**
(Month) (Day) (Year)

8. AGE: Years **71** Months **2** Days **18** If less than one day _____ hr. _____ min.

9. Birthplace **Iowa** **Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business _____

MOTHER FATHER { 12. Name **John Davis**
13. Birthplace **Iowa** (City, town, or county) (State or foreign country)
14. Maiden name **Mary Ellen Welch**
15. Birthplace **Iowa** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Deane Stiles**
(b) Address _____

17. (a) **Richmond Mo** (b) Date thereof **May 1, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Richmond Mo**

18. (a) Signature of funeral director **Alaude Pichard**

(b) Address **Excelsior Springs Mo**

19. (a) **May 1, 1940** (b) **Mrs. Bea M. Clarke**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Clay**
(c) City or town **Excelsior Springs Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. **Courtney Apartments**
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **19** 19**40**
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Stroke Apoplexy**

Due to _____

Due to **GAH**

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **180**

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **Mrs W. B. Wysocki** Coroner

Address **Liberty Clay Mo Missouri**

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 6-4-10

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Robert Ray

Registered Apprentice No. *226*

working under my personal supervision.

Signed *Claude C. McKay*

Licensed Embalmer No. *2757*

P. O. Address *Excelsior Spgs. Va.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.