

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 528

Primary Registration District No. 4214

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County MACON
(b) City or town CALLAO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 John Peter Mott 300

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

4. Sex MALE 5. Color or race White 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife Effie Mott 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased October 27 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 5 20 hr. _____ min.

9. Birthplace RANDOLPH Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

MOTHER FATHER { 12. Name JAMES T. Mott

13. Birthplace RANDOLPH Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name FRANCI'S KING

15. Birthplace _____ Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Effie Mott

(b) Address CALLAO Mo. R.F.D.

17. (a) Int. Lion Cem. (b) Date thereof 4-19-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial

18. (a) Signature of funeral director J.E. Edward

(b) Address Bevier Mo.

19. (a) May 26 1940 (b) Mrs. S.H. Baker
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County MACON
(c) City or town CALLAO RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 17
year 1940 hour 7 minute 12 M.

21. I hereby certify that I attended the deceased from 4/11/40 to 4/17/40, 1940
that I last saw him alive on 4/16/40, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocardial Infarction Duration 3 days

Due to Branchial Pneumonia 2 days

Due to Hypertensive Heart Disease

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

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

23. Signature A.L. Durdona (M. D. or other) 3/16
Address Callao, Mo. Date signed 5/4/40

RECEIVED

District Health Officer No. 10

District File Number 6-40-1212

Date Filed JUN 12 1940

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.....

M. G. Edwards

....., Registered Apprentice No.

working under my personal supervision.

Signed *M. G. Edwards*

Licensed Embalmer No. 1961

P. O. Address Berwick Me

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

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