DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25882

AUG 21 1940

Registration District No. 625

Primary Registration District No. 3031

Registrar's No. 99

1. PLACE OF DEATH:
(a) County Nodaway
(b) City or town Maryville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 812 West Ist. St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether
In this community 53 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Nodaway
(c) City or town Maryville
(If outside city or town limits, write "RURAL")
(d) Street No. 812 West Ist St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Katherine Jamima Moody 300
3. (b) If veteran, name war ____
3. (c) Social Security No. None
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Isaac Enzier Moody
6. (c) Age of husband or wife if alive 86 years
7. Birth date of deceased July (Month) 17 (Day) 1940 (Year)

8. AGE: Years 83 | Months | Days II | If less than one day ____ hr. ____ min.

9. Birthplace Taylorsville (City, town, or county) N.C. (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Conrad C. Benifield
13. Birthplace ____ (City, town, or county) N.C. (State or foreign country)
MOTHER
14. Maiden name Katherine Dockery
15. Birthplace ____ (City, town, or county) N.C. (State or foreign country)
16. (a) Informant's [redacted] D. S. Moody
(b) Address Maryville Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Hill Cemetery
18. (a) Signature of funeral director John W. Price
(b) Address Maryville Mo.
19. (a) 7-29-40 (Date received local registrar) (b) Mamie E Clardy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27 year 1940 hour 12:45 minute P M.
21. I hereby certify that I attended the deceased from July 22, 1940 to July 29, 1940 that I last saw her alive on July 29, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pleural Pneumonia	
Due to	
Due to	
Other conditions Contract Thrombosis (Include pregnancy within 3 months of death)	
Major findings: Of operations 10 days	
Of autopsy none	

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? 55 (Specify type of place)
While at work? ____ (e) Means of injury ____
23. Signature K C Cunn (M. D. or other)
Address Maryville Mo Date signed 7-29-40

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shoul
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very imp

82 B

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed John W. Price.

Licensed Embalmer No. 3229.

P. O. Address Maryville Mo.

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

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

No. 2B
2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25-882

Registration District No. 625 Primary Registration District No. 3031 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Madison
(b) City or town Marquette (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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (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.

3. (a) PRINT FULL NAME Katherine Jemima Moody
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 83 Months — Days 11 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

PHYSICIAN'S CERTIFICATION

20. DATE OF DEATH: Month July day 27 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Lobar Pneumonia	
Bronchial Pneumonia	
Due to	
Due to	
Other conditions Cerebral Thrombosis (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? (Specify type of place)
While at work? (e) Means of injury

23. Signature T. L. Lemmon (M.D. or other)
Address Marquette Mo Date signed