

No. 2
11-10-39
5-17-39
I X21

NOV 15 1940
Registration District No. 408

Primary Registration District No. 3020

Registrar's No. 188

1. PLACE OF DEATH:

(a) County Jasper
Carthage

(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: McCune Brooks Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 Days
(Specify whether _____)

In this community 55 years
years, months or days

3. (a) PRINT FULL NAME Felix W. Wescott

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mary E. Wescott

6. (c) Age of husband or wife if alive Dead years

7. Birth date of deceased Nov. 14th. 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

79 9 3 hr. min.

9. Birthplace Unknown Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business Farming

MOTHER FATHER

12. Name Joe Wescott

13. Birthplace Unknown Ill.
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Watson

15. Birthplace Unknown Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Luther Wescott

(b) Address Jasper, Mo.

17. (a) Burial (b) Date thereof 10/20-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stafford Cem.

18. (a) Signature of funeral director Chas. J. Teeter

(b) Address Jasper, Mo.

19. (a) Oct. 19, 1940 (b) E. J. McIntire, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper

(c) City or town Jasper, Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 4 1/2 Miles S W of Jasper
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17
year 1940 hour 3 PM minute _____ M.

21. I hereby certify that I attended the deceased from Oct 9 1940, to Oct 17 1940
that I last saw him alive on Oct 17 1940, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Septicemic Pneumonia

Due to: acute Intestinal Obstruction

Due to: _____

Other conditions: uremia
(include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Many edemas

Of operations: _____

Of autopsy: 0

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? 865
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature H. B. Boyd, M.D. M.D. (M. D. or other) 1

Address Carthage Date signed 10-19-40

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

9
5
2

122B

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.....

Phas J. Tuter....., Registered Apprentice No.
 working under my personal supervision.

Signed Phas J. Tuter.....

Licensed Embalmer No. 2566

P. O. Address Garner Mo

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35-5-36**

Registration District No. **408**

Primary Registration District No. **3020**

Registrar's No. **188**

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

ROWENA MOORE

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Carthage**
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **Felix H. Wescott**

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

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **wid**

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 **79** Months **9** Days **3** If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **17** year **1940** 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 **Hypostatic pneumonia N.M. 10** Duration _____

Due to **acute intestinal obstruction**

Due to _____ Other conditions **removal - cause not known - but a terminal condition** (Include pregnancy within 3 months of death)

Major findings: _____ Of operations _____

Of autopsy _____ **12212** 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? _____

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

23. Signature _____ (M. D. or other) _____ Address _____ Date signed _____

SUPPLEMENTARY

