DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

REC'D NOV 15 1940

Registration District No. 408

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35618

Primary Registration District No. 5565

Registrar's No. 185

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

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Rural - UNION TOWNSHIP
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Route # 3, Carthage,
(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 78 Years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper

(c) City or town Rural - Union Township.
(If outside city or town limits, write "RURAL")

(d) Street No. Route # 3.
(If rural, give location)

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

3. (a) PRINT FULL NAME Georgia A. Moss

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Femal

5. Color or race White

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

6. (b) Name of husband or wife S. T. Moss.

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

7. Birth date of deceased Oct. (Month) 7, (Day) 1858 (Year)

8. AGE: Years 82 | Months 2 | Days 13 | If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Samuel W. Elliott
13. Birthplace _____ (City, town, or county) England (State or foreign country)

MOTHER
14. Maiden name Diana Payne
15. Birthplace _____ (City, town, or county) Tenn. (State or foreign country)

16. (a) Informant's own signature Mrs. John W. Spence
(b) Address Route # 3, Carthage, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-40 (Month) (Day) (Year)
(c) Place: burial or cremation Center Cemetery

18. (a) Signature of funeral director Ed. C. Ulmer
(b) Address 1208 Garrison, Carthage, Mo.

19. (a) Oct. 8, 1940 (Date received local registrar) (b) E. J. McIntire, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 7th, year 1940 hour 6:45 minute P. M.

21. I hereby certify that I attended the deceased from Sept. 6, 1940, to Oct. 6, 1940 that I last saw h. alive on Oct 6 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic myocardial Insufficiency	
Due to Senility	
Due to	
Other conditions (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 H. E. Byrd M.D. (M. D. or other)
Address Carthage Mo Date signed 10-8-40

(Licensed Embalmer's Statement on Reverse Side)

40-11-559.

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.....

Licensed Embalmer No. 2222

P. O. Address. Carthage

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

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