DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 14 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2916

Registration District No. 406 Primary Registration District No. 4240 Registrar's No.

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

1. PLACE OF DEATH:
(a) County: Jasper
(b) City or town: Carl Junction
(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: 12 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jasper 49
(c) City or town: Carl Junction 3
(If outside city or town limits, write "RURAL")
(d) Street No.: Gen. Delivery 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: Jennie Moffitt
3. (b) If veteran, name war:
3. (c) Social Security No.:
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: 2 Widowed
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Dec. (Month) 10 (Day) 1864 (Year)
8. AGE: Years 76 ~~75~~ Months 0 Days 25 If less than one day hr. min.
9. Birthplace: Fayetteville, (City, town, or county) / Arkansas (State or foreign country)
10. Usual occupation: at home
11. Industry or business:
MOTHER FATHER
12. Name: James L. Carlisle
13. Birthplace: unknown (City, town, or county) / Kentuckey (State or foreign country)
14. Maiden name: Anna Wilcox
15. Birthplace: unknown (City, town, or county) / Ohio (State or foreign country)
16. (a) Informant: Mrs W. E. Ucker
(b) Address: Chickasea, Okla.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 1/7/41 (Month) (Day) (Year)
(c) Place: burial or cremation: Farmington, Ark.
18. (a) Signature of funeral director: Hodge-Nelson
(b) Address: Webb City, Missouri
19. (a) Jan 6 1941 (Date received local registrar) (b) Roy E. Graves (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 5 year 1941 hour 1 minute 15 P. M.
21. I hereby certify that I attended the deceased from Jan 1, 1941, to Jan 5, 1941, that I last saw her alive on Jan 4, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to arterial sclerosis	
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: D. L. Alberty (M. D. ~~or other~~) D
Address: Carl Junction Date signed: Jan 6 1941

(Licensed Embalmer's Statement on Reverse Side)

4-2-106

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 E. N. Hedge, Registered Apprentice No. ..... working under my personal supervision.

Signed E. N. Hedge

Licensed Embalmer No. 2865-9

P. O. Address Shelby City

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, fact should be so stated above.

o. 2B
-21-40
X22659

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MISSOURI STATE BOARD OF HEALTH

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Registration District No. 406 Primary Registration District No. 4240 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Carl Junction
(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)

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 Jennie Moffitt

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 wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec - 10 - 1864
(Month) (Day) (Year)

8. AGE: Years 76 ~~75~~ Months 0 Days 25 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) JAN 31 - 1941 (Date received local registrar) (b) R. H. Mall (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 5 year 1941 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	
Due to	
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 O. L. Alberty (M. D. or other)
Address Carl Junction Date signed

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

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State File No. .....

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

1. PLACE OF DEATH:

(a) County .....

(b) City or town .....
(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)

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 .....

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

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

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 | Months | Days | If less than one day ..... hr. ..... min

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

10. Usual occupation .....

11. Industry or business .....

WHEN LATHER
12. Name .....
13. Birthplace ..... (City, town, or county) (State or foreign country)

WHEN 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day ..... year ..... 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.

Immediate cause of death ..... Duration .....

Due to .....

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 ..... (M. D. or other) .....
Address ..... Date signed .....