

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

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Miller Mo. R.R.
(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 of location)

(d) Length of stay: In hospital or institution 5 yrs. 1 (Specify whether years, months or days)

In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence

(c) City or town R.R. 55
(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 Charles Robert Mose

3. (b) If veteran, name war L

3. (c) Social Security No. L

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Sarah Elizabeth Mose

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased 4-6-1876
(Month) (Day) (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|-----------|-----------|-----------|----------------------|
| <u>64</u> | <u>10</u> | <u>27</u> | hr. _____ min. |

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name George H. Mose

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Sarah Mose

(b) Address Miller Mo. R.R.

17. (a) Buried (b) Date thereof 3-4-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hazelwood S.P.R.

18. (a) Signature of funeral director Morris - Leiman

(b) Address Miller Mo.

19. (a) 4-1-41 (b) W. S. Baum
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day March
year 1941 hour 5:30 minute _____ A. M.

21. I hereby certify that I attended the deceased from 2-28-41
3-1-41 1941, to 3-1-41 1941,
that I last saw him alive on 11/3/2 1941,
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage
intestine

Due to _____

Due to Intestine
obstruction

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

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: _____

Of operations _____

Of autopsy _____

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)

(e) Means of injury _____

23. Signature W. S. Baum (M. D. or other) _____

Address Miller Date signed 3-3-41

RECEIVED

District Health Officer No. 6,

District File Number 441-600

Date Filed APR 10 1941

122 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

G. B. Seiman

Licensed Embalmer No. 3297

P. O. Address Miller 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11183

Registration District No. 469

Primary Registration District No. 5630

Registrar's No.

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Lincoln T. 10
(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 Chas Robert Mase
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 m

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
64 10 29 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 3
year 1944 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 Removal of intestinal (Duration)

Due to probably an ulcer

Due to intestinal obstruction
cause not determined!

Other conditions perhaps adhesions
(Include pregnancy within 3 months of death)

Major findings: from an appendectomy

Of operations year ago

Of autopsy 1944

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? _____

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

23. Signature Ed. J. Bruner (M. D. or other)

Address in Illinois Date signed 6-9-44

SUPPLEMENTARY

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

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1941

S-11183