

S. No. 2
M-1-4-41
v. 5-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27508**
Registrar's No. **3166**

FILED SEP 12 1941
Registration District No. **397**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3004 Charlotte
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
55 Yrs. (Specify whether
In this community **55 Yrs.** / years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Jackson** **048**
(c) City or town **Kansas City** **3**
(If outside city or town limits, write "RURAL") **8**
(d) Street No. **3004 Charlotte**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country **M**

3. (a) PRINT FULL NAME **Miss Sarah Moats**
3. (b) If veteran, name war **No.** 3. (c) Social Security No. **no.**
4. Sex **Fe.** 5. Color or race **Wh.** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife **XXXX** 6. (c) Age of husband or wife if alive **XXXX** years
7. Birth date of deceased **Aug. 9th.** **1853**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug.** day **22**
year **1941** hour **4** minute **30 A.M.**
21. I hereby certify that I attended the deceased from **July 19**
1941, to **Aug 22** **1941**
that I last saw **her** alive on **Aug 21** **1941**
and that death occurred on the date and hour stated above.

8. AGE: Years **88** Months **0** Days **12**
If less than one day **hr.** **min.**

Immediate cause of death **myocardial failure**
Due to **General arterio-sclerosis**
Due to **Inactive left femur (crack)** **7 weeks**
Other conditions **1860**
(Include pregnancy within 3 months of death)

9. Birthplace **Galia Co.** **Ohio**
(City, town, or county) (State or foreign country)
10. Usual occupation **Home**
11. Industry or business
12. Name **John W. Moats**
13. Birthplace **Galia Co.** **Ohio**
(City, town, or county) (State or foreign country)
14. Maiden name **Melinda Prose**
15. Birthplace **Galia Co.** **Ohio**
(City, town, or county) (State or foreign country)
16. (a) Informant **Mrs. R.C. Woodbury (sister)**
(b) Address **3004 Charlotte K.C.Mo.**
17. (a) **Burial** (b) Date thereof **8-23-41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Forest Hill**
18. (a) Signature of funeral director **Eylar Funeral Home**
(b) Address **1800 Linwood K.C.Mo.**
19. (a) **8/22/41** (b) **M. M. Crow**
(Date received local registrar) (Registrar's signature)

Major findings: **no fracture**
Of operations. **no autopsy**
Of autopsy. **no**
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) **accident**
(b) Date of occurrence **July 13 1941** **123**
(c) Where did injury occur? **Forest Hill - Jackson Mo.**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home
While at work? (Specify type of place) **fell on floor**
(e) Means of injury **floor**
23. Signature **W. B. ...** (M. D. or other)
Address **1124 Professional Bldg** Date signed **8/24/41**

VI 1938

Pa. 1124

Mr. Herbert Valentine West, 1850

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 Chas. N. Jiff
Licensed Embalmer No. 2644
P. O. Address 1850 Pinewood

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.