

FILLED NOV 18 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Valley 35474
State File No.

Registration District No. 528

Primary Registration District No. 5722 A

Registrar's No.

1. PLACE OF DEATH:

(a) County: Macon
(b) City or town: Rural Valley, F.P.
(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
In this community: 1 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Macon
(c) City or town: Rural
(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 Sept day 30
year 1941 hour 4 minute 15 a.m.
21. I hereby certify that I attended the deceased from Sept 7 to Sept 29 1941
that I last saw him alive on Sept. 29 1941
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Thrombosis Duration 78 hrs.

Due to: Automobile accident 29 days

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?

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

23. Signature: A.P. Durden (M. D. or other)
Address: Calcas, Mo Date signed: 10/4/41

3. (a) PRINT FULL NAME: Emmette E. Mott

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

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

6. Name of husband or wife: Cora Mott 6. (c) Age of husband or wife if alive: 58 years

7. Birth date of deceased: April 17 1881
(Month) (Day) (Year)

8. AGE: Years 60 Months 5 Days 13 If less than one day hr. min.

9. Birthplace: Macon Co. Mo (City, town, or county) (State or foreign country)

10. Usual occupation: Farming

11. Industry or business:

12. Name: James J. Mott

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

14. Maiden name: Mary J. King

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

16. (a) Informant: Mrs. E. E. Mott
(b) Address: Calcas, Mo

17. (a) Burial (b) Date thereof: 10-2-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation
18. (a) Signature of funeral director: Stephen Gooding
(b) Address: Macon, Mo
19. (a) Oct 10-1941 (b) H. B. Barber
(Date received local registrar) (Registrar's signature)

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

761
0
0

4511

RECEIVED.

District Health Officer No. 10

District-File Number 11-41-2032

Date Filed NOV 13 1941

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.....

C. L. Stephens

Licensed Embalmer No. 3057

P. O. Address. Macon, 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. **35474**
Registrar's No.

Registration District No. **528**

Primary Registration District No. **5722A**

1. PLACE OF DEATH

(a) County **Mason**
(b) City or town **Rural**
(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 **Emmett E. Motts**

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 **Apr. 17 1884**
(Month) (Day) (Year)

8. AGE: Years **66** Months **5** Days **13** If less than one day hr. min.

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

MOTHER FATHER

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 **Sept** 19**41** year. hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....; that I last saw him/her alive on..... 19.....; and that death occurred on the date and hour stated above.

Physician's cause of death: **Thrombosis of coronary artery (Automobile Accident)**

Due to **Callus with Fracture of WRs**
Due to **object (Bridge)**

Other conditions (Include pregnancy within 3 months of death)
1700-8

Major findings: Of operations..... Of autopsy.....
1700-8

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) **accident**
(b) Date of occurrence **Sept. 13, 1941**
(c) Where did injury occur? **Callas, Mason Mo**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public place

(Specify type of place)
While at work? **no** (e) Means of injury **truck**

23. Signature **A. L. Dunder** (M. D. or other) **Dr**
Address **Callas** Date signed **12/17/41**

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

SUPPLEMENTARY

S-35474