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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35589

FILLED NOV 12 1941
Registration District No. 605

Primary Registration District No. 4309

Registrar's No. 2

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Osborne
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ✓
In this community ✓
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid
(c) City or town Osborne
(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 _____

3. (a) PRINT FULL NAME Mable Moore
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓

4. Sex m 5. Color or race Cal
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife ✓
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased 10-8-1921
(Month) (Day) (Year)

8. AGE: Years 19 Months 11 Days 1
If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business Farming

12. Name Mable Moore
13. Birthplace Osborne
(City, town, or county) (State or foreign country)
14. Maiden name Jessie Ray Moore
15. Birthplace Osborne
(City, town, or county) (State or foreign country)

16. (a) Informant Mable Moore
(b) Address Osborne

17. (a) Burial (b) Date thereof Sept. 11, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Osborne Mo.

18. (a) Signature of funeral director James Earl Hays
(b) Address Osborne Mo.

19. (a) 11-4-41 (b) D. K. Kinschulte
(Date received local registrar) (Registrar's signature)

5-4 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 9 1941.
year _____ hour 10A minute _____ M.

21. I hereby certify that I attended the deceased from 9-3-41
9-9-41 19 to 9-3-41 19;
that I last saw him alive on 9-3-41 19;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to Pneumonia

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? _____

While at work _____ (Specify type of place) Means of injury 0

23. Signature [Signature] (M. D. or other)
Address Osborne Mo. Date signed 9/17/41

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

202

32086-41

RECEIVED

District Health Office No. 2,

District File Number 1141-1500

Date Filed 11/10/41

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.....

P. O. Address.....

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. **35589**

Registration District No. **605**

Primary Registration District No. **4359**

Registrar's No. **1**

1. PLACE OF DEATH:

(a) County **New Madrid**
(b) City or town **Carson**
(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 **MOBEE Marks**

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

4. Sex **m** 5. Color or race **B** 6. (a) Single, widowed, married, divorced **2**

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

7. Birth date of deceased **Oct 8 1921**
(Month) (Day) (Year)

8. AGE: Years **19** Months **11** Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of business _____

MOTHER FATHER { 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) **11-4-41** (b) **Dr. Geo. Husted**
(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** Day _____ Year **1941** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to **Labor**
Due to _____

Other conditions (Include pregnancy within 3 months of death) **108**

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? _____

23. Signature **Dr. Geo. Husted** (M. D. or other) _____
Address **Paris, Mo.** Date signed _____

SUPPLEMENTARY

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

MOBEE Marks

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

8

32086