CS. No. 2
(—11-10-39
v. 5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 11 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

4015

State File No.

Registration District No. 903 Primary Registration District No. 6212 Registrar's No.

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

1300

1. PLACE OF DEATH:
(a) County Worth
(b) City or town Rural Fletchall 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 years, months or days)
In this community 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Worth
(c) City or town Grant city "Rural"
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location) U
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME CHARLES MOLER
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 Married
6. (b) Name of husband or wife Mary Moler
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 24 (Day) 1861 (Year)

8. AGE: Years 80 Months 8 Days 4 If less than one day hr. min.

9. Birthplace Omega (City, town, or county) Kans (State or foreign country)
10. Usual occupation Farmer
11. Industry or 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 Mary Moler
(b) Address Grant City, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 30 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Fletchall cem.
18. (a) Signature of funeral director Arch C. Dunlee
(b) Address Grant City, Mo.
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 28 year 42 hour 6 PM minute M.
21. I hereby certify that I attended the deceased from 1-26-42 to 1-28 19 42, 19 , that I last saw him alive on 1-28 19 42 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis
Due to Lobar Pneumonia
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

Duration

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 Cutley Neal (M. D. or other)
Address Grant City Date signed 1-28-42

(Licensed Embalmer's Statement on Reverse Side)

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 Arch C. Dunlee

Licensed Embalmer No. 3252

P. O. Address Grant City 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, above space should be left blank.

V. S. No. 2B
10M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4015

Registration District No. 913 Primary Registration District No. 6212 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County: Worth
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME: Charles Moler
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
7. Birth date of deceased: May (Month) 24 (Day) 1867 (Year)
8. AGE: Years 86 Months 8 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
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) (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) Feb. 2, 1942 (Date received local registrar) Arlene Scudder (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 him alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pneumonia	
Due to: Bronchial	
Due to	
Other conditions (Include pregnancy within 3 months of death) 107	

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 (M. D. or other)
Address Date signed