FILED MAR 10 1943

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

7919

Do not use this space.

1. PLACE OF DEATH
(a) County Texas
(b) Township Lynch #2
or
(c) City
Registration District No. 356 10
Primary Registration District No. 6207 8
Registered No. 2
(d) Street No. , St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Alzada Sophia Mosher
(a) Residence, No. Texas Co. / Prescott Mo St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Not Married

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 3, 1922

7. AGE Years 20 Months 6 Days 14 If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeping
9. Industry or business in which work was done, as saw mill, bank, etc. Family
10. Date deceased last worked at this occupation (month and year) Dec 1942
11. Total time (years) spent in this occupation 5 Months

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Prescott Mo

FATHER
13. NAME E. E. Mosher
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wilkes County Tenn

MOTHER
15. MAIDEN NAME Lucy Jones
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Prescott Mo

17. INFORMANT (ADDRESS) E. E. Mosher Prescott Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Prescott Cem DATE 12-21-42

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Smith Ferguson Licking Mo

20. FILED Feb. 6 1943 Mrs. Ella Duff Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-17 1942

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 3:00 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Accidental	
Burns	
Burns Second Degree	

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Home
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) [illegible], M. D.
(Address) [illegible]

(Licensed Embalmer's Statement on Reverse Side)

124

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

1 X16605

RECEIVED
District Health Officer No. 6,
District File Number 343150
Date Filed _____

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 Me
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed Eubert E Ferguson

Licensed Embalmer No. 3945

P. O. Address Licking Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

S. No. 2B
M—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. 7919

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

1. PLACE OF DEATH:
(a) County: Texas
(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: Mo (b) County: Texas
(c) City or town: Prescott (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: Alzada S. Moshes
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: S
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: June (Month) 3 (Day) 1922 (Year)
8. AGE: Years 20 Months 6 Days 4 If less than one day ..... hr. ..... min.
9. Birthplace: ..... (City, town, or county) Mo (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) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 7 year 1942 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	Duration
Accidental from gunshot wounding	
Due to: left breast	
~~Due to~~ This occurred on the girls Fathers Farm	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: Date given above is correct	
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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY