

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

ED AUG 11 1943

Registration District No. ....

Primary Registration District No. 3000

Registrar's No. 201

1. PLACE OF DEATH:

(a) County Adair

(b) City or town "Rural" Kirksville

(c) Name of hospital or institution: Ellis Hospital

(d) Length of stay: In hospital or institution 4 1/2 days

In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair

(c) City or town "Rural" R. No. 2, Kirksville

(d) Street No. Rural R. No. 2

(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Mary Moots

3. (b) If veteran, name war.....

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Willis Moots

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased October 24 1879

8. AGE:

Years	Months	Days	If less than one day
63	8	21	.....hr. ....min.

9. Birthplace Adair Co. Missouri

10. Usual occupation Housewife

11. Industry or business.....

12. Name John Horton

13. Birthplace Penn.

14. Maiden name Ann Marcuess

15. Birthplace Virginia

16. (a) Informant Willis Moots

(b) Address Kirksville, Mo.

17. (a) Burial (b) Date thereof 7/21/43

(c) Place: burial or cremation Refuge Cemetery

18. (a) Signature of funeral director

(b) Address Kirksville, Mo.

19. (a) 7/26/43 (b) Dr. J. P. Wayman

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15

year 1943 hour 3:00 minute P: M.

21. I hereby certify that I attended the deceased from 7/10/43 to 7/15/43

that I last saw her alive on 7-15-43

and that death occurred on the date and hour stated above.

Immediate cause of death Heart block

Due to.....

Due to.....

Other conditions nephritis

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?.....

(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 R. R. Ellis (M. D. or other)

Address Kirksville, Mo. Date signed 7-20-43

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 10

District File Number 8-431281

Date Filed AUG 10 1943

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 DEE Kelly

Licensed Embalmer No. 4181

P. O. Address Hicksville

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

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

AUG 13 1943

Registration District No. 1

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

- (a) County Adair  
 (b) City or town Kearville  
 (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 Mary Moore

3. (b) If veteran,
- 
- name war \_\_\_\_\_

3. (c) Social Security
- 
- No. \_\_\_\_\_

4. Sex
- Female
- 
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 \_\_\_\_\_
- 
- (Month) (Day) (Year)

8. AGE: Years
- 63
- Months \_\_\_\_\_ Days \_\_\_\_\_
- 
- If less than one day \_\_\_\_\_ min.

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

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
- July
- Day
- 10
- 
- Year
- 1943
- Hour
- 3:00
- minute
- 7
- M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 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

- Due to \_\_\_\_\_

- 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 sta-  
tistically.

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 \_\_\_\_\_

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

SUPPLEMENTARY

131 b

Heart block  
Chronic  
Nephritis

S-24197