

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29623
Registrar's No. _____

Rebirth into al 19340-43

Registration District No. 370

Primary Registration District No. 6255

1. PLACE OF DEATH:

(a) County WAYNE
(b) City or town RURAL TWP 19
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1 Crown Jump
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 22 yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County WAYNE
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. NEAR HIRAM, MO
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME FRANCIS WAYFAETTER MOYERS

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 NANCY E. MOYERS 6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased Aug. 15 1864
(Month) (Day) (Year)

8. AGE: Years 78 Months 5 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation FARMER

11. Industry or business _____

MOTHER FATHER { 12. Name Michael MOYERS
13. Birthplace MO.
(City, town, or county) (State or foreign country)
14. Maiden name SALLIE CREEK
15. Birthplace MO.
(City, town, or county) (State or foreign country)

16. (a) Informant NANCY E. MOYERS
(b) Address HIRAM, MO.

17. (a) BURIAL (b) Date thereof 1-20-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HOUSE CEM. MARQUAND

18. (a) Signature of funeral director BAKER FUNERAL HOME
(b) Address LUTESVILLE, MO

19. (a) 6/14/43 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 19
year 1943 hour 9:00 minute 45 A.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 Cerebral Hemorrhage

Due to Atherosclerosis

Due to _____

Other conditions gza
(Include pregnancy within 3 months of death)

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 John H. ... (M.D. or other)
Address _____ Date signed 6/2/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1222 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4
District File Number 943-26
Date Filed 9-8-43

S-19340

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 J. E. Graham

Licensed Embalmer No. 4010

P. O. Address Lutesville, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29623

Registration District No. 370

Primary Registration District No. 6255

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Wayne
(b) City or town Rural Cowan Twp.
(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 _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME Francis L. Mayer

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 _____

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

7. Birth date of deceased Aug 10 1888
(Month) (Day) (Year)

8. AGE: Years 78 Months _____ Days _____ If less than one day _____ min.

9. Birthplace Mo.
(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) _____ (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) Francis Mayer
(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 _____ year 1943 hour _____ minute _____ 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 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 _____

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

SUPPLEMENTAL

112

S-19340