

NOV 6 1943

Registration District No. 253

Primary Registration District No. 4384

Registrar's No.

1. PLACE OF DEATH:

(a) County Nodaway
(b) City or town Skidmore
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None (Specify whether)

In this community Most of Life years, months or days

3. (a) PRINT FULL NAME Emogene Louisa Moorhead

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 W

6. (b) Name of husband or wife Theodore Parker Moorhead "deceased" 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb - 14 - 1864 (Month) (Day) (Year)

8. AGE: Years 79 Months 8 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation Homemaker

11. Industry or business _____

12. Name George L. Manchester

13. Birthplace New York (City, town, or county) (State or foreign country)

14. Maiden name Louisa M. Kilburn

15. Birthplace Vermont (City, town, or county) (State or foreign country)

16. (a) Informant Jack Moorhead

(b) Address Kansas City, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-43 (Month) (Day) (Year)

(c) Place: burial or cremation Masonic Skidmore

18. (a) Signature of funeral director Campbell Funeral Home

(b) Address 951 S. Main, Mansfield, Mo

19. (a) Oct. 20-43 (Date received local registrar) (b) Mrs. Ralph Scott (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Nodaway
(c) City or town Skidmore 0702 (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 Oct. day 18th year 1943 hour 7 minute - P.M.

21. I hereby certify that I attended the deceased from Oct. 10, 1943 to Oct. 18, 1943 that I last saw her alive on Oct. 18, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia
Due to 8 wks. in bed with Fracture of femur

Other conditions (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? _____

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

23. Signature L. G. Bynon (M. D. or other) DO
Address Skidmore, Mo Date signed 10/20/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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..... *William Campbell*

Licensed Embalmer No..... *2620*

P. O. Address..... *Manville*

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. *nov*

Registration District No. *253*

Primary Registration District No. *4384*

Registrar's No. _____

1. PLACE OF DEATH:
(a) County *Nodaway*
(b) City or town *Skidmore*
(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 *Emogene Louisa Moorhead*
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 *w*

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

7. Birth date of deceased *Feb. 14*
(Month) (Day) (Year)

8. AGE: Years *79* Months *8* Days *4* (If less than one day, _____ min.)

9. Birthplace *Kent*
(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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(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 *Oct* Day *18* Year *1943* Hour _____ Minute _____ M.

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

Immediate cause of death *Myocardial infarction*

pneumonia

Due to *8 hrs in bed with fracture of femur*

Due to _____

Other conditions (Include pregnancy within 3 months of death) *1860*

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following: Accident *fall in home*

(a) Accident, suicide, or homicide (specify) *fall in home*
(b) Date of occurrence *7-4-43*

(c) Where did injury occur? *Skidmore, Nodaway, Mo.*
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In home, while closing windows at night.
(Specify type of place) (e) Means of injury _____

23. Signature *F. G. Burton* (M. D. or other) *Des*
Address *Skidmore, Mo.* Date signed *11/18/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

35407