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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 380.25

DEC 6 1943  
Registration District No. 13

Primary Registration District No. 5291

Registrar's No. 82

1. PLACE OF DEATH:

(a) County clay  
(b) City or town Liberty mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: clay co Home. 5  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution few days (Specify whether years, months or days)

3. (a) PRINT FULL NAME MINNIE Mosby

3. (b) If veteran, name war 720 3. (c) Social Security No. 720

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife J.G. Mosby 6. (c) Age of husband or wife if alive, years 5

7. Birth date of deceased Sept 5 1864  
(Month) (Day) (Year)

8. AGE: Years 79 Months 2 Days 22 If less than one day hr. min.

9. Birthplace clay co near Kearney  
(City, town, or county) (State or foreign country)

10. Usual occupation Pensioner

11. Industry or business

12. Name marion crowley

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

14. Maiden name Margaret Huffaker

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

16. (a) Informant Mrs P.E. Wornal (b) Date thereof 11/29/43

(c) Address Liberty, Missouri

17. (a) Burial (b) Date thereof 11/29/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Liberty, Mo.

18. (a) Signature of funeral director Jesse Hill Funeral Home

(b) Address Liberty, Mo.

19. (a) 11-28-43 (b) Deleu Early  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County clay 24  
(c) City or town Liberty 5  
(If outside city or town limits, write "RURAL") 1  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 27  
year 1943 hour 5 minute 00 P.M.

21. I hereby certify that I attended the deceased from Nov 13, 1943 to Nov 27, 1943  
that I last saw he alive on Nov 27, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Shock

Due to Fractured Right Hip 2 wks.

Due to

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) accident

(b) Date of occurrence Nov 13, 1943

(c) Where did injury occur? Liberty Clay Mo.  
(City of town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
In home  
While at work? (Specify type of place) (e) Means of injury OV

23. Signature Quinton Malley (M. D. or other) M.D.  
Address Liberty Mo Date signed 11-28-43

Duration

2 wks.

2 wks.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

12-3-43

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.....

*my self*

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

*Victor E. Aminger*

Licensed Embalmer No. ....

*2896*

P. O. Address.....

*Liberty, 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.

Registration District No. 73 Primary Registration District No. 5291

1. PLACE OF DEATH:  
(a) County Clay  
(b) City or town Liberty  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Clay Co. Home  
(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 Minnie Mesby  
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: Sept 6 1906  
(Month) (Day) (Year)  
8. AGE: Years 79 Months 2 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) \_\_\_\_\_  
(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 Nov day 27  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death: Shock

Due to \_\_\_\_\_  
Due to Fracture Right Hip  
Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: 1951  
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)  
(e) Means of injury \_\_\_\_\_  
23. Signature G. W. Henderson (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

**SUPPLEMENTARY**

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

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

38035