

DEPARTMENT OF COMMERCE  
BUREAU OF VITAL STATISTICS  
FILED FEB 17 1945

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

Registration District No. 341

Primary Registration District No. 6152A

Registrar's No. 4

**1. PLACE OF DEATH:**

(a) County Stoddard

(b) City or town Rural, Liberty Twp.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Dexter, Mo.  
(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

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Stoddard 103

(c) City or town Rural, Liberty Twp. 0  
(If outside city or town limits, write "RURAL") 0

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country ii

**3. (a) PRINT FULL NAME** Lona Mossman

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Louie Mossman 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased: April 24 1906  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan. day 12 year 1945 hour 2 minute 45 p. a. M.

21. I hereby certify that I attended the deceased from Jan 10, 1945, to Jan 12, 1945 and that I last saw him alive on Jan 5, 1945 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>38</u>	<u>8</u>	<u>18</u>	hr. _____ min. _____

Immediate cause of death: Tuberculosis Tuberculosis

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace Wayne Co., Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

**PHYSICIAN**

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy yes

Underline the cause to which death should be charged statistically.

**11. Industry or business**

12. Name George Campbell

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

14. Maiden name Ella Bazzell

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) yes

(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 S.S. Davis (M. D. or other) \_\_\_\_\_  
Address Dexter, Mo. Date signed 1-13-45

16. (a) Informant Louie Mossman  
(b) Address Dexter, Mo.

17. (a) Burial (b) Date thereof 1/14/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arm. Dowdy Cem.

18. (a) Signature of funeral director Blankenship-Strickland  
(b) Address Dexter, Mo.

19. (a) 1-26-45 (b) Nora Smith  
(Date received local registrar) (Registrar's signature)

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

303

2129

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2,

District File Number 245-144

Date Filed 2-7-45

1007-21 1954

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. Strickland.....

Licensed Embalmer No. 3479.....

P. O. Address Wester, 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.