S. No. 2
M—8-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 11 1945

Registration District No. 1933

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17445

Primary Registration District No. 5708-5709, Registrar's No.

1. PLACE OF DEATH:

(a) County McDonald

(b) City or town Rural, Erie 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 50 Yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonald

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Anderson MO, R,#,3
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Margret Moser

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 Chas, Moser

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

7. Birth date of deceased Dec. (Month) 12th, (Day) 1888 (Year)

8. AGE: Years 56 | Months 1 | Days 28 | If less than one day ___hr. ___min.

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

10. Usual occupation Housekeeper

11. Industry or business

FATHER
12. Name Joseph Wasson
13. Birthplace (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name Evelyn Corsten
15. Birthplace (City, town, or county) Georgia (State or foreign country)

16. (a) Informant Chas Wasson
(b) Address Anderson MO, R,# 3

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-1945 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ Owsley Cemetry

18. (a) Signature of funeral director Chas. Williams
(b) Address Goodman MO,

19. (a) 6/14/45 (Date received local registrar) (b) Mrs C.W. Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb, day 10
year ### 1945 hour 12 Noon minute ___ M.

21. I hereby certify that I attended the deceased from Feb. 9, 1945, to Feb 10, 1945
that I last saw her alive on Feb. 10, 1945
and that death occurred on the date and hour stated above.

Cause	Duration
Immediate cause of death: Cerebral Hemorrhage	
Due to: High Blood pressure	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J.C. Edmondson (M. D. ~~another~~)
Address Stella Mo Date signed 6/10/45

464 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6
District File Number 645-643
Date Filed JUN 7 1945

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.....

Licensed Embalmer No.....

P. O. Address.....

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.