

FILED SEP 21 1945

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

Registration District No. 219

Primary Registration District No. 3056

Registrar's No. 168

1. PLACE OF DEATH:  
 (a) County Randolph  
 (b) City or town Moberly  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 414 E. Rollins  
(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 Randolph  
 (c) City or town Moberly  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 414 E. Rollins  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME FLORENZA MIRANDA PARK  
 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 Widowed  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_  
 7. Birth date of deceased: Sept 30<sup>th</sup> 1864  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Sept. day 5<sup>th</sup>  
 year 1945 hour 11 minute 00 P.M.  
 21. I hereby certify that I attended the deceased from Aug 26/45 to Sept 5/45, 1945;  
 that I last saw him alive on Aug 26/45, 19\_\_\_\_, and that death occurred on the date and hour stated above.  
 Immediate cause of death: Myocarditis Duration months

8. AGE: Years 80 Months 11 Days 5  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
 Due to High Blood Pressure yrs.  
 Other conditions (Include pregnancy within 6 months of death) \_\_\_\_\_  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy 939

9. Birthplace All 1  
(City, town, or county) (State or foreign country)  
 10. Usual occupation at home  
 11. Industry or business \_\_\_\_\_  
 12. Name Josh Banks  
 13. Birthplace All 1  
(City, town, or county) (State or foreign country)  
 14. Maiden name Susan Martin  
 15. Birthplace All 1  
(City, town, or county) (State or foreign country)  
 16. (a) Informant J. H. Reath  
 (b) Address Moberly Mo  
 17. (a) Burial (b) Date thereof 19-8-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Trenton Mo  
 18. (a) Signature of funeral director G. G. Robertson  
 (b) Address Garard, Ind  
 19. (a) 7-6-45 (b) Uma Love  
(Data received local registrar) (Registrar's signature)

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 suicide  
 (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 L. E. Hulse (M. D. or other) \_\_\_\_\_  
 Address Moberly Mo Date signed 9/6/45

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

1036

STATE OF MARYLAND

RECEIVED  
District Health Officer No. 10  
District File Number 9-45-1492  
Date Filed SEP 19 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 E. J. Robertson

Licensed Embalmer No. 2468

P. O. Address Laurel, Md

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.