

FILED JAN 15 1945  
Registration District No. 373

STANDARD CERTIFICATE OF DEATH

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

Primary Registration District No. 4544

Registrar's No. 68

1. PLACE OF DEATH:

(a) County Webster Co  
(b) City or town Niangua mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Niangua mo  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: in hospital or institution 7 (Specify whether  
In this community life  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Webster 12  
(c) City or town Niangua mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? X (Yes or No)  
If yes, name country 1

3. (a) PRINT FULL NAME ELLA JANE MOSE

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 21 1880  
(Month) (Day) (Year)

8. AGE: Years 64 Months 4 Days 25 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Webster Co mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name T. B. Clifton

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

14. Maiden name unknown

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

16. (a) Informant John Mose

(b) Address in care of Mrs

17. (a) Burial (b) Date thereof 12-18-45  
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Coppany

18. (a) Signature of funeral director Ray Rainey

(b) Address Marsh field mo

19. (a) 12/28/45 (b) J. H. Anthony  
(Date received copy registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 16  
year 1945 hour 8 minute 15 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic interstitial nephritis

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

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

Major findings: Of operations \_\_\_\_\_  
Of autopsy 1318

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 W. F. Schmidt (M. D. or other)  
Address Niangua mo Date signed Dec 27 1945

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

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

MOTHER FATHER

JAN 16 1946

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**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 *Tex James*

Licensed Embalmer No. 3312

P. O. Address Marshfield, 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.**