

FILED JAN 11 1946

State File No.

Registration District No. 376

Primary Registration District No. 6282

Registrar's No.

1. PLACE OF DEATH:
 (a) County WRIGHT
 (b) City or town NORWOOD (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: NORWOOD REST HOME #4 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 8 MONTHS years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County WRIGHT
 (c) City or town NORWOOD (If outside city or town limits, write "RURAL")
 (d) Street No. NORWOOD - REST HOME (If rural, give location)
 (e) Citizen of foreign country? N.O. (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME EMIMA MOODY
 3. (b) If veteran, name war NONP
 3. (c) Social Security No. NONP

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month DEC day 23 year 1945 hour 11 minute 0 P.M.

4. Sex FEMALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife JOHN MOODY
 6. (c) Age of husband or wife if alive 85 years
 7. Birth date of deceased OCT 13 1865 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 12 1945 to DEC 23 1945 that I last saw her alive on Dec 21 1945 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
80 2 10 hr. min.

Immediate cause of death Pneumonia
 Duration

9. Birthplace HUMBOLT NEBRASKA (City, town, or county) (State or foreign country)
 10. Usual occupation HOUSEWIFE

Due to _____
 Due to _____
 Other conditions lung diabetes (Include pregnancy within 6 months of death)

MOTHER FATHER
 11. Industry or business _____
 12. Name JOHN NEWSAM
 13. Birthplace NOT KNOWN (City, town, or county) (State or foreign country)
 14. Maiden name NOT KNOWN
 15. Birthplace NOT KNOWN (City, town, or county) (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy _____
ADDITIONAL MEDICIAN SUPPLEMENTARY INFORMATION REQUESTED

16. (a) Informant Earl Adell
 (b) Address 225 East Scott Springfield
 17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 26 1945 (Month) (Day) (Year)
 (c) Place: burial or cremation BAKER CEM.
 18. (a) Signature of funeral director J.A. Steffe
 (b) Address MANSCFIELD MO.
 19. (a) 12-29-45 (Date received local registrar) (b) Mrs. A. R. Wopshaw (By _____)

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 [Signature] (M. D. or other) _____
 Address [Address] Date signed 12/27 1945

RECEIVED
District Health Officer No. 6;
District File Number 146-33
Date Filed JAN 9 1946

JAN 21 1946

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 Fr. A. Stoff
Licensed Embalmer No. 3221
P. O. Address Myersfield Pa

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)
If this body is not embalmed, fact should be so stated above.

Registration District No. 376

Primary Registration District No. 6282

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Snowwood
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Emma Mosely

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 M

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

7. Birth date of deceased Oct 13, 1865
(Month) (Day) (Year)

8. AGE: Years 80 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (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 _____ Day _____ Year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

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) _____

(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 _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

PERSONAL

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

42819