

FILED NOV 26 1946

Registration District No. 294

Primary Registration District No. 3056

Registrar's No. 243

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:  
Woodland Hospital  
(If not in hospital or institution, write street number & 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. 928 Henry St  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Joseph B. Mayes  
3. (b) If veteran, name war ✓  
3. (c) Social Security No. ✓

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov day 21<sup>st</sup>  
year 1946 hour 9 minute 00 A. M.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: Apr 15<sup>th</sup> 1861  
(Month) (Day) (Year)

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

8. AGE: Years Months Days If less than one day  
85 7 6 hr. min.

Immediate cause of death  
Coronary thrombosis Immediate  
Due to Bronchopneumonia with uremia 2 days  
Due to \_\_\_\_\_ 1 wks

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
10. Usual occupation Retired Farmer

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
12. Name William T. Mayes  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name Sarah Robb  
15. Birthplace \_\_\_\_\_ (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) \_\_\_\_\_  
(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 \_\_\_\_\_

16. (a) Informant Ralph D Mayes  
(b) Address Moberly, Mo  
17. (a) Burial (b) Date thereof Nov 23<sup>rd</sup> 46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Kendall, Shelby Co.  
18. (a) Signature of funeral director Mahan and Son  
(b) Address Moberly, Mo  
19. (a) Nov 23-46 (b) Leah Moberly  
(Date received local registrar) (Registrar's signature)

23. Signature Sam Ellis (M. D. or other) \_\_\_\_\_  
Address 208 N 4<sup>th</sup> St Moberly Date signed 11/22/46

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

2  
3  
39  
56571

Duration  
Immediate  
2 days  
1 wks  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

RECEIVED  
District Health Officer No. 10  
District File Number: 46-213  
Date Filed NOV 25 1948

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.....

*Frank J. DeWitt*

Licensed Embalmer No. ....

3021

P. O. Address.....

*Moberly, 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.**

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(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:  
(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

3. (a) PRINT FULL NAME

Joseph B Meyer  
3. (b) If veteran name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased April 15 1884  
(Month) (Day) (Year)

8. AGE: Years 85 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) Nov 23-46 (b) Leola Williams-Lowe  
(Date received local registrar) (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 1946 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 \_\_\_\_\_

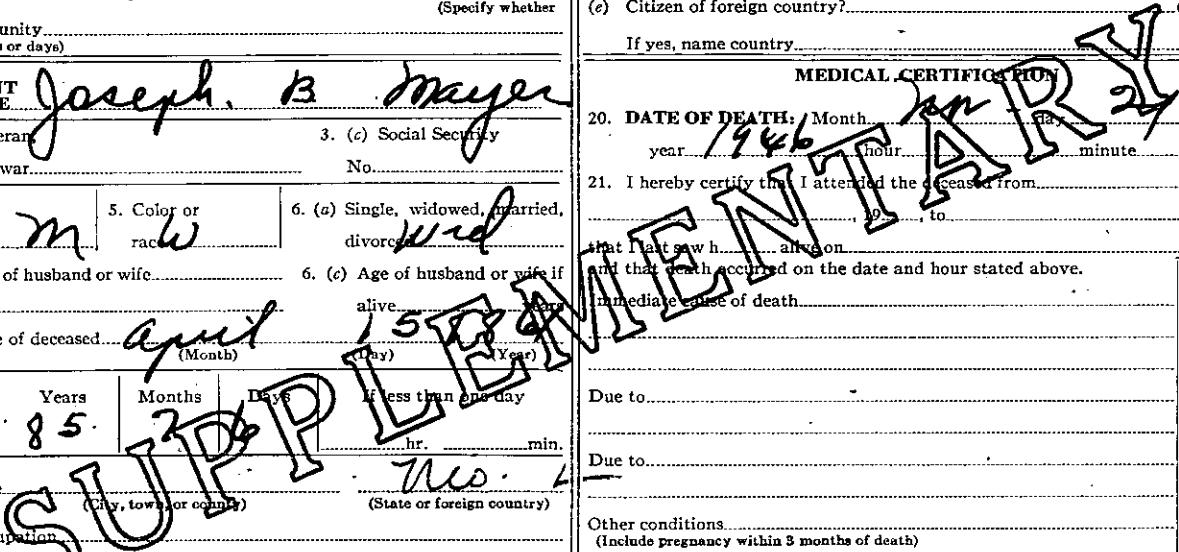
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_



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

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