

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

FILED MAR 12 1947

Registration District No. **157**

Primary Registration District No. **3028**

Registrar's No. **39**

1. PLACE OF DEATH:
 (a) County **Jasper**
 (b) City or town **Carthage**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
McCune-Brooks Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3 days**
(Specify whether
 In this community **40 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jasper**
 (c) City or town **Carthage**
(If outside city or town limits, write "RURAL")
 (d) Street No. **518 Olive St.**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME **Fred Moss**
 3. (b) If veteran, name war **---**
 3. (c) Social Security No. **---**

4. Sex **male** 5. Color or race **white**
 6. (a) Single, widowed, married, divorced **divorced**
 6. (b) Name of husband or wife **Daisy Moss**
 6. (c) Age of husband or wife if alive **60** years
 7. Birth date of deceased **JANUARY 9 1885**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	62	1	15	hr. _____ min. _____

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

10. Usual occupation **retired farmer**

11. Industry or business **---**

MOTHER FATHER { 12. Name **James E. Moss**
 13. Birthplace **unknown**
(City, town, or county) (State or foreign country)
 14. Maiden name **Jane Fingerly**
 15. Birthplace **unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Hattie Banderman**
 (b) Address **St. Clair, Mo.**

17. (a) **burial** (b) Date thereof **Feb 25, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **OAKHILL Cemetery**

18. (a) Signature of funeral director **Knell Mortuary**
 (b) Address **Carthage, Mo.**

19. (a) **2-25-47** (b) **J. B. Clinton M.D.**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **24**
 year **1947** hour **6:20** minute **0** M.

21. I hereby certify that I attended the deceased from **2-20** to **2-24**, 19**47**
 that I last saw **alive** on **2-23-47** and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis**
 Due to **ruptured bladder**
 Due to **trauma**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **15 2**
 Of autopsy **15 2**
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
 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? _____ Means of injury **0**

23. Signature **J. B. Clinton** (M. D. or other) _____
 Address **Carthage Mo** Date signed **2-25-47**

47-7-160

APR 2 1947
MAR 20 1947

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 W. Kuehl Jr.*

Licensed Embalmer No. *4440*

P. O. Address..... *Carthage, 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.

Registration District No. 157

Primary Registration District No. 3028

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Carthage
(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) (Specify whether

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 _____

3. (a) PRINT FULL NAME Fred mose

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 _____ year _____ hr. _____ min.

7. Birth date of deceased Jan 9 1899
(Month) (Day) (Year)

8. AGE: Years 62 Months _____ Days _____ (if less than one day) _____ hr. _____ min.

9. Birthplace mo
(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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2-27-47 (b) R. B. Clinton
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February 24
year 1947 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 _____

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 _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

S-5186