

No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33436
Registrar's No. 98

Registration District No. 337

Primary Registration District No. 6147

1. PLACE OF DEATH:
(a) County Shelby
(b) City or town Emden - Rural
(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 Life (Specify whether _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Shelby 102
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) _____
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME BENJAMIN FRANKLIN MORELAND
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 Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 8 1857
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
90 11 19 _____ hr. _____ min.

9. Birthplace Marion Co Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Retired Farmer

11. Industry or business _____
12. Name Washington Moreland
13. Birthplace Va (City, town, or county) (State or foreign country)
14. Maiden name Isabelle Robertson
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Gilbert Moreland
(b) Address Shelbyville Mo
17. (a) Burial (b) Date thereof Sept 29 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Emden Cemetery
18. (a) Signature of funeral director E.P. Thompson
(b) Address Shelbyville Mo
19. (a) Oct 10-47 (b) Keith Jarner
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 27
year 1947 hour 11:15 minute P M.
21. I hereby certify that I attended the deceased from Sept 29
1947 to Sept 26 1947
That I last saw him alive on Sept 26 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Acute bronchitis (Specify type of place)
Due to _____
Due to _____

Other conditions Senility
(Include pregnancy within 3 months of death)
Major findings: No operation
Of operations _____
Of autopsy No 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 H. D. L. [unclear] (M. D. or other)
Address Shelbyville Mo Date signed Oct 3 47

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

RECEIVED
District Health Officer No. 10
District File Number 10-47-1392
Date Filed OCT 13 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.

Myself

Signed.....
Licensed Embalmer No. 1632
P. O. Address. Shelbyville, 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.