

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35366

FILED NOV 4 1947
Registration District No. 294

Primary Registration District No. 300-6

Registrar's No. 247

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Moberly
(c) Name of hospital or institution Mc Cormick Hospital
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Randolph
(c) City or town Moberly
(If outside city or town limits, write "RURAL")
(d) Street No. 100 Howley St
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Claudie Young
(b) If veteran, name war
(c) Social Security No.

4. Sex Female
5. Color or race col
6. (a) Single, widowed, married, divorced married
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 1 1903
(Month) (Day) (Year)

8. AGE: Years 44 Months 10 Days _____ If less than one day hr. _____ min. _____

9. Birthplace MO
(City, town, or county) (State or foreign country)
10. Usual occupation House wife

11. Industry or business _____
12. Name Will Boggs
13. Birthplace MO
(City, town, or county) (State or foreign country)
14. Maiden name Stella Shelby
15. Birthplace MO
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Clarence Young
(b) Address 100 Howley St
17. (a) Burial (b) Date thereof Oct 30 47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Moberly, MO
18. (a) Signature of funeral director Robert L. Carr
(b) Address 417 N. 5th St
19. (a) Oct 30 47 (b) Clarence Young
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 27
year 1947 hour 7 minute 45 P. M.
21. I hereby certify that I attended the deceased from Oct. 27, 1947 to Oct 27, 1947
that I last saw him alive on Oct. 27, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial asthma
Due to myocarditis
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations 93 P
Of autopsy _____

Duration hrs.
hrs.
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 D
23. Signature P. L. McCormick (M. D. or other) _____
Address Moberly MO Date signed 11/27/47

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

Rev. 1-11-31 N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED
DEPARTMENT OF HEALTH OFFICER No.
47-14
NOV - 3 1947
Date Filed

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 Robert L. Carr
Licensed Embalmer No. 3190
P. O. Address Mobile, 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, above space should be left blank.