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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 23 1948

Registration District No. 316

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6074

State File No. 44569

Registrar's No. 9

1. PLACE OF DEATH:

(a) County ST FRANCIS
(b) City or town FRANK CLAY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: NONE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 50 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County ST FRANCIS
(c) City or town FRANK CLAY
(If outside city or town limits, write "RURAL")
(d) Street No. NONE
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JULIA MOSIER

3. (b) If veteran, name war NO 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
(b) Name of husband or wife DANIAL MOSIER 6. (c) Age of husband or wife if alive 82 years
7. Birth date of deceased JULY 17 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 5 8 hr. min.

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

10. Usual occupation MERCHANT

11. Industry or business GROCERY STORE

12. Name JOHN HAMPTON
13. Birthplace UNKNOWN IRELAND
(City, town, or county) (State or foreign country)
14. Maiden name MIRTLE CAMPBELL
15. Birthplace UNKNOWN IRELAND
(City, town, or county) (State or foreign country)

16. (a) Informant Ira Mosier
(b) Address Bonne Terre Mo.

17. (a) Burial (b) Date thereof Dec 29 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LEADWOOD MO

18. (a) Signature of funeral director Bert L. Boyer
(b) Address Leadwood MO

19. (a) 1-15-48 (b) Ether Rudloff
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 26
year 1947 hour 5 minute 10 a.m.
21. I hereby certify that I attended the deceased from 12-24 to 12-26, 1947
that I last saw her alive on 12-24
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction Duration 22

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)
pre L hyp 2 months previous

Major findings: Of operations _____

Of autopsy 1867

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence 94

(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 N. O. Kael (M. D. or other) _____
Address Bonne Terre Mo Date signed 1-6-48

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

MOTHER FATHER

PHYSICIAN
ADDITIONAL
SUPERVISOR
INFORMANT
REQUESTED

RECEIVED

District Health Officer No. 4
District File Number 148-133
Date Filed 1-27-48

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

Bert L. Boyer

Licensed Embalmer No.

3445

P. O. Address

Leadwood, 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. 316 Primary Registration District No. 6074

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Frankelay
(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 _____
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 Julia Mosier
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July Day 10 Year 1947
hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____, and that death occurred on the date and hour stated above. Immediate cause of death _____

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 _____

Duration
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

7. Birth date of deceased July 17 1917
(Month) (Day) (Year)
8. AGE: Years 75 Months _____ Days _____ If less than one day hr. _____ min. _____
9. Birthplace (City, town, or county) _____ (State or foreign country) MO

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

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) _____ (b) _____
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident ✓
(b) Date of occurrence 10-10-47
(c) Where did injury occur? Frankelay, St. Francois Co. ✓
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, or public place?
In her home in kitchen ✓
While at work? no (Specify type of business) ✓
23. Signature [Signature] (M.D.) _____
Address _____ Date signed 2-5-48

SUPPLEMENTARY

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

1000
1000
1000

5-44569