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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JAN 19 1948

Registration District No. 42

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1000

State File No. 265

Registrar's No. 24

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph's Hospital O (If not in hospital or institution, write street, number or location)
(d) Length of stay: In hospital or institution: 2 days (Specify whether years, months or days)
In this community: 2 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Kansas (b) County: Marshall 999
(c) City or town: Marysville 14 (If outside city or town limits, write "RURAL")
(d) Street No.: Unknown 0 (If rural, give location)
(e) Citizen of foreign country? No. 2 (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Lester William Moser
3. (b) If veteran, name war: None
3. (c) Social Security No.: None
4. Sex: Male O
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married 1
6. (b) Name of husband or wife: Mollie E. Moser
6. (c) Age of husband or wife if alive: 43 years
7. Birth date of deceased: September (Month) 20 (Day) 1903 (Year)

8. AGE: Years 44 Months 3 Days 14 If less than one day ___ hr. ___ min. 1
9. Birthplace: Unknown (City, town, or county) Colorado. (State or foreign country) 1
10. Usual occupation: Engineer & Fireman
11. Industry or business: Union Pacific R.R.
MOTHER FATHER
12. Name: Nelson Moser
13. Birthplace: Unknown (City, town, or county) Illinois (State or foreign country) 1
14. Maiden name: Iva Root
15. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country) 9 1
16. (a) Informant: Mrs. Mollie E. Moser
(b) Address: Marysville, Kansas.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: Jan. 4, 1948 (Month) (Day) (Year)
(c) Place: burial or cremation: Marysville, Ks.
18. (a) Signature of funeral director: Walter Meierhoffer
(b) Address: 1946 Colhoun St., St. Joseph, Mo.
19. (a) Jan. 12, 1948 (Date received local registrar) (b) E. L. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: January day: 4th year: 1948 hour: 8 minute: 10 A.M.
21. I hereby certify that I attended the deceased from: January 2nd, 1948, to: January 4, 1948, that I last saw him alive on: 1-4, 1948 and that death occurred on the date and hour stated above.

Duration

Immediate cause of death: Pulmonary atherosclerosis
Due to: Coronal insufficiency 12 weeks
Due to: Cardiac Decompensation
Other conditions (Include pregnancy within 3 months of death):

Major findings:
Of operations: 0
Of autopsy: as above + dilatation + hypertrophy of right heart & pericardial constriction & adhesion of liver

PHYSICIAN
Underline the cause of 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? (Specify type of place) O
While at work? (e) Means of injury:

23. Signature: L. E. Venar M.D. (M. D. or other) 1-5-48
Address: St. Joseph, Mo. Date signed:

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

FEB 11 1948

FEB 4 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.....Elbert C. Harrington.....

Licensed Embalmer No.....3258 Missouri.....

P. O. Address.....St. Joseph, 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.