

1. PLACE OF DEATH:

(a) County Johnson
(b) City or town Warrensburg Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Nace Nursing Home, 116 King St. 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 wk (Specify whether
In this community 1 wk
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette 54
(c) City or town Higginsville 2
(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 Lester Lafayette Moots

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 0 5. Color or race W
6. (a) Single, widowed, married, divorced or widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased Dec 19 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
x65x78 6 2 hr. min.

9. Birthplace Briston Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name Unkown 7
13. Birthplace Unkown (City, town, or county) (State or foreign country)
14. Maiden name Unkown
15. Birthplace Unkown (City, town, or county) (State or foreign country) 9

16. (a) Informant Located these items in his bible

(b) Address Higginsville Mo.

17. (a) Burial (b) Date thereof Higginsville Mo.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director [Signature]

(b) Address Higginsville Mo.

19. Jan 24 1948 (Date received local registrar) (b) Sarah Ann [Signature] (Registrar's signature) 4-7-48

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23-1948
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 6-23-48
_____, 19____, to 6-23-48, 19____;
that I last saw him alive on 6-23-48, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death:
Dishete mullitic
Chronic nephritic

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 61
Of autopsy _____

Duration
3
2
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 _____

23. Signature R. Lee Cooper MD (Date or other)
Address Warrensburg Mo Date signed 6/23/48

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

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 Forrest A. Johnson
Licensed Embalmer No. 412/55
P. O. Address Higginville

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.