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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35469**

FILED NOV 24 1948

Registration District No. _____

Primary Registration District No. **3000**

Registrar's No. **330**

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

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirkville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Laughlin
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon **61**
(c) City or town Macon **3**
(If outside city or town limits, write "RURAL")
(d) Street No. 319 Union **2**
(If rural, give location)
(e) Citizen of foreign country? -- (Yes or No) **1**
If yes, name country --

3. (a) PRINT FULL NAME Mrs. Bertha Moss

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

4. Sex Female 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 11 years 1881

7. Birth date of deceased: 2/28/37 (Month) (Day) (Year)

8. AGE: 11 Years 3 Months 28 Days If less than one day ---- hr. ---- min.

9. Birthplace: Callao Mo (City, town, or county) (State or foreign country)

10. Usual occupation Domestic

11. Industry or business _____

12. Name John L. Cook **7**

13. Birthplace Unknown (City, town, or county) (State or foreign country)

14. Maiden name Edaline Dallas

15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lawrence white

(b) Address Callao Mo RFD

17. (a) Burial (b) Date thereof 11-11-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri

18. (a) Signature of funeral director A.S. Edwards

(b) Address Bevier Missouri

19. (a) 11-18-48 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 9
year 1948 hour 4 minute 15 AM.

21. I hereby certify that I attended the deceased from October 29, 1948 to Nov 9, 1948,
that I last saw her alive on Nov 9, 1948,
and that death occurred on the date and hour stated above.

Immediate cause of death Thyroid crisis with cardiac collapse *Duration*

Due to Hyperthyroidism

Due to _____

Other conditions Myocardial weakness and auricular fibrillation
(Include pregnancy within 3 months of death)

Major findings: Thyroidectomy

Of operations _____
Of autopsy ** **63B**

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 2

23. Signature Carl Laughlin (M.D. or other) 20.

Address Kirksville, Mo. Date signed 11-12-48

NOV 22 1948

RECEIVED
District Health Officer No. 10
District File Number 11-48-128
Date Filed NOV 22 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 *M. J. Edwards*

Licensed Embalmer No. 1961

P. O. Address *Berwick, 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.