No. 300
10-48

FILED AUG 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23227

State File No. .....

BIRTH NO. ..... REG. DIST. NO. 139 PRIMARY REG. DIST. NO. 40225 Registrar's No. 55

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

1. PLACE OF DEATH
a. COUNTY Holt. Oregon Mo
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Brown Nursing Home 4

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Rock Port Mo
b. COUNTY Atchison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 3
d. STREET ADDRESS (If rural, give location) 1 0

3. NAME OF DECEASED (Type or Print)
a. (First) Emma
b. (Middle) Janet
c. (Last) Moody

4. DATE OF DEATH (Month) July (Day) 25 (Year) 1949

5. SEX 1 Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Dec 14 - 1882
9. AGE (In years last birthday) 67 | IF UNDER 1 YEAR Months 6 Days 1 | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Keep Wife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Nodaway County
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME James Thomas Watson
13b. MOTHER'S MAIDEN NAME Ida Howard Watson
14. NAME OF HUSBAND OR WIFE David Frank Moody

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Mrs John Luther
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	CEREBRAL HEMORRHAGE	3 MONTHS
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	CARCINOMA OF CERVIX	9 MONTHS
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		171X

19a. DATE OF OPERATION NO
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 22, 1949, *to* July 25, 1949, *that I last saw the deceased alive on* July 25th, 1949, *and that death occurred at* 12:45 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Howard E. Colbin D.O.
23b. ADDRESS Oregon Mo
23c. DATE SIGNED July 25, 49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 27-49
24c. NAME OF CEMETERY OR CREMATORY Rock Port Mo
24d. LOCATION (City, town, or county) (State) Rock Port Mo

DATE REC'D BY LOCAL REG. 7-27-49
REGISTRAR'S SIGNATURE J. Arens 122
25. FUNERAL DIRECTOR'S SIGNATURE G. E. Bertram
ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
AUG 2 1948
DISTRICT
HEALTH OFFICE
CAMERON, MO.

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 C E Butram, Student Embalmer No. ..... working under my personal supervision.

Student .....
Student Embalmer

Signed C E Butram

Licensed Embalmer No. 1964

P. O. Address Rock Port Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.