

FILED DEC 16 1949

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43556**

BIRTH NO. _____		REG. DIST. NO. 369		PRIMARY REG. DIST. NO. 6252		Registrar's No. 8	
1. PLACE OF DEATH a. COUNTY WAYNE				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY WAYNE			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MILL SPRING		c. LENGTH OF STAY (In this place) 18-10-22		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MILLS PRING			
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) ALEXANDER c. (Last) MOSS			4. DATE OF DEATH (Month) (Day) (Year) OCT 27 1949				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH OCT 5-1876	
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months 10 Days 22		IF UNDER 1 HOUR Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) MILL SPRING		12. CITIZEN OF WHAT COUNTRY U.S.P.	
13a. FATHER'S NAME JAMES MOSS		13b. MOTHER'S MAIDEN NAME CORDILLIA ROBERTSON		14. NAME OF HUSBAND OR WIFE 			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME JACK MOSS WILLIAMS VILLE MO 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Emphysema of lungs ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Heart lesion					INTERVAL BETWEEN ONSET AND DEATH 5-8/10
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug. 19 49 to Oct 27, 1949 , that I last saw the deceased alive on Oct 22, 1949 , and that death occurred at 3:00 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Dr. James M. D. Friedman MD				23b. ADDRESS Piedmont MO		23c. DATE SIGNED 11-1-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE OCT 29-49		24c. NAME OF CEMETERY OR CREMATORY CARSON HILL		24d. LOCATION (City, town, or county) (State) MILL SPRING MO.	
DATE REC'D BY LOCAL REG. Nov. 9, 1949		REGISTRAR'S SIGNATURE Suzie E. Piles 340		25. FUNERAL DIRECTOR'S SIGNATURE Amos W. Rich		ADDRESS Piedmont	

(Licensed Embalmer's Statement on Reverse Side)

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

12-9-49

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Date filed

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

me

Student Embalmer No.

working under my personal supervision.

Signed *Marvin E. Bowler*

Signed
Student Embalmer

Licensed Embalmer No. *426*

P. O. Address *Edmund Ave*

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.