

FILED JUL 6 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21239

State File No.

BIRTH NO. _____ REG. DIST. NO. 298 PRIMARY REG. DIST. NO. 4448 Registrar's No. 13

1. PLACE OF DEATH a. COUNTY <u>Ray</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Lawson</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Lawson</u>	
c. LENGTH OF STAY (in this place) <u>10 months</u>		d. STREET ADDRESS (If rural, give location) <u>0890</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. FULL NAME OF HOSPITAL OR INSTITUTION	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>HENRY</u>	b. (Middle) <u>WILMOUTH</u>	c. (Last) <u>MOFFITT</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>May 27 1950</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept 29-1861</u>	9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>28</u>	IF UNDER 4 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Louisville Kentucky</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Leonard Moffitt</u>	13b. MOTHER'S MAIDEN NAME <u>Harriet McFarland</u>	14. NAME OF HUSBAND OR WIFE <u>Gamma Moffitt</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>L. H. Moffitt</u>	ADDRESS <u>Lawson Mo</u>
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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 <u>1 wk</u> <u>3 wks</u> <u>584 hr</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Failure</u> <u>Chronic Myocardi</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Cholelithiasis</u> <u>Hepatitis</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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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) <u>Lawson Ray Mo</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 May 1, 1950, to May 27, 1950, that I last saw the deceased alive on May 26, 1950, and that death occurred at 5:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Arthur Buehler</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Lawson Mo</u>	23c. DATE SIGNED <u>May 29 1950</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>May 30 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Excelsior Springs Mo</u>
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DATE REC'D BY LOCAL REG. <u>May 29 1950</u>	REGISTRAR'S SIGNATURE <u>Mrs. Raymond Groves</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Farmer Priskard</u>	ADDRESS <u>Lawson Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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JUN 9

RECEIVED

District Health Officer No. 8;

District File No. _____

Date Filed _____

6-29-50

JUN 9 100

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Lindeek K. Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs

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.