No. 300
10-48

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

FILED NOV 20 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39682

BIRTH NO. _____ REG. DIST. NO. 375 PRIMARY REG. DIST. NO. 4551 Registrar's No. 43

1. PLACE OF DEATH
a. COUNTY: Wright
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hartville
c. LENGTH OF STAY (in this place): 30 Yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: Wright 114
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hartville
d. STREET ADDRESS (If rural, give location):

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

4. DATE OF DEATH (Month) (Day) (Year): 11 5 1950

5. SEX: F
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 3-7-1878
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months 7, Days 28 — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Richland, Mo
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: William Jasper McCoy
13b. MOTHER'S MAIDEN NAME: Rachel Henry
14. NAME OF HUSBAND OR WIFE: J. R. Moody

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: J. R. Moody
ADDRESS: Hartville, Mo.

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days

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.

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19a. DATE OF OPERATION:
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* Nov 2, 1950, *to* Nov 5, 1950, *that I last saw the deceased alive on* Nov 4, 1950, *and that death occurred at* 2:50P *m., from the causes and on the date stated above.*

23a. SIGNATURE: J. R. Mott (Degree or title): M D
23b. ADDRESS: Hartville Mo
23c. DATE SIGNED: 11-7-50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-8-1950
24c. NAME OF CEMETERY OR CREMATORY: Steele Memorial
24d. LOCATION (City, town, or county) (State): Wright County, Mo

DATE REC'D BY LOCAL REG.: 11/16/50
REGISTRAR'S SIGNATURE: O L Garner 346
25. FUNERAL DIRECTOR'S SIGNATURE: Gene E Holden
ADDRESS: Hartville, Mo.

(Licensed Embalmer's Statement on Reverse Side)

County File Number 1150-124
Date Filed 11-18-50

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 Gene E. Holdren

Licensed Embalmer No. 3865

P. O. Address Hartville Mo

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

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