

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34273

State File No.

FILED NOV 14 1955

BIRTH NO. _____ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 295

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, write RURAL and give town(ship)) <u>Sedalia</u>	c. LENGTH OF STAY (In this place) <u>32 days</u>	c. CITY OR TOWN <u>Sedalia</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bothwell Hospital</u>		STREET ADDRESS (If rural, give location) <u>about 3 miles NW Buena Vista Home, Route 4 Sedalia</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>ETTA</u>	b. (Middle) <u>MAE</u>	c. (Last) <u>MOSBY</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>November 8, 1955</u>
---	------------------------	------------------------	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 28, 1881</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
-------------------------	----------------------------------	--	--	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Pettis County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	--	---	---

13a. FATHER'S NAME <u>Sam Schneider</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Lutgen</u>	14. NAME OF HUSBAND OR WIFE <u>Robert F. Mosby (dec.)</u>
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Ralph H. Mosby, Route 3, Sedalia, Mo.</u>	ADDRESS <u>Sedalia, Mo.</u>
---	---	---	--------------------------------

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) <u>PULMONARY INFARCTS</u>		
	ANTECEDENT CAUSES MORBID CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (a) STATING THE UNDERLYING CAUSE LAST. DUE TO (b) <u>MULTIPLE INTRAMURAL THROMBI.</u> DUE TO (c) <u>CORONARY SCLEROSIS.</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>1. CHRONIC GLOMERULAR NEPHRITIS</u> <u>2. CHRONIC CHOLELITHIASIS.</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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) (Min.)	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 JAN., 1955, to 8 NOV., 1955, that I last saw the deceased alive on 8 NOV., 1955, and that death occurred at 5:30 P.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Paul B. Gonsler MD</u>	(Degree or title) <u>MD</u>	23b. ADDRESS <u>Sedalia, Mo.</u>	23c. DATE SIGNED <u>8 Nov 55</u>
---	-----------------------------	-------------------------------------	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>11/10/1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Highland Memorial Gardens, Sedalia, Mo.</u>	24d. LOCATION (City, town, or county) (State)
--	--------------------------------	--	---

DATE REC'D BY LOCAL REG. <u>11-9-55</u>	REGISTRAR'S SIGNATURE <u>Lavinia Cooney Deputy</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>DW. Eckhart</u>	ADDRESS <u>Sedalia, Mo.</u>
--	---	--	--------------------------------

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

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.....
Signature of Student Embalmer

Signed *Russell O. Maag*.....

Licensed Embalmer No. 4

P. O. Address *Sedalia*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.