

STANDARD CERTIFICATE OF DEATH

State File No. 28287

SEP 16 1940
197

Registration District No.

Primary Registration District No. 5276

Registrar's No.

1. PLACE OF DEATH:

(a) County. Clay
(b) City or town. Gallatin AWA
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days 2 no illn

2. USUAL RESIDENCE OF DECEASED:

(a) State. Mo (b) County. Clay
(c) City or town. Rural
(If outside city or town limits, write "RURAL")
(d) Street No. North Kansas City, Mo
(If rural, give location) RS
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME FLORENCE MOYER

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex. Fe 5. Color or race. W
6. (a) Single, widowed, married, divorced, single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased. May 22 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 11 hr. min.

9. Birthplace North Kansas City, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Carl Moyer

13. Birthplace Des Moines Ia
(City, town, or county) (State or foreign country)

14. Maiden name Margaret M. Mihal

15. Birthplace Des Moines Ia
(City, town, or county) (State or foreign country)

16. (a) Informant Carl Moyer

(b) Address North Kansas City, Mo

17. (a) Burial (b) Date thereof Aug 12 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem Mo.

18. (a) Signature of funeral director Morton Funeral Home

(b) Address North Kansas City, Mo

19. (a) Aug 11, 40 (b) John M. Weston
(Date of local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 11
year 1940 hour 5 AM minute _____ M.

21: I hereby certify that I attended the deceased from _____ to _____ 19____

that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxiation

Due to _____

Due to _____

Other conditions Russell C. Porter
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

063 (Specify type of place) _____
While at work? (e) Means of injury _____

23. Signature Mrs W. L. Moyer (M.D. or other) _____

Address Liberty Clay Co. Missouri

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

-4

161R

RECEIVED
District Health Officer No. 8,
District File Number
9-10-40
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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Harold L. Benson*

Licensed Embalmer No. 3605

P. O. Address *North Kedonia*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **28287**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **197**

Primary Registration District No. **5276**

Registrar's No.

1. PLACE OF DEATH

(a) County **Clay**
(b) City or town **Saffatun T. P.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Lourence Moyer**

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **S**

6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one year min.

9. Birthplace (City, town, or county) or foreign country

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (b) (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: month **Aug** day **11** year hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19

that the last saw him alive on 19

that the death occurred on the date and hour stated above.

Immediate cause of death **asphyxiation** Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **Probably due to suffocation**

(b) Date of occurrence **to**

(c) Where did injury occur? **entrapped by bed cloth** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place, or by Mother's body? **accident** (Specify type of place) While at work? means of injury

23. Signature (M. D. or other)

Address Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MADE IN U.S.A.—PERMANENT RECORD

MOORE PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH

