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

FILED OCT 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31072

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 3635

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1919 Skiles
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 2 (Specify whether years, months or days)
In this community: 65 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

(c) City or town: Kansas City
(If outside city or town limits write "RURAL")

(d) Street No. 1919 Skiles 0
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Whitcomb Augustus Moffett

3. (b) If veteran, name war: None

3. (c) Social Security No.: No

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Mar.

6. (b) Name of husband or wife: Bertha Ethel Moffett

6. (c) Age of husband or wife if alive: 60 years

7. Birth date of deceased: May (Month) 28th (Day) 1873 (Year)

8. AGE: Years 67 | Months 3 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace: East Lynn (City, town, or county) Mo. (State or foreign country) 0

10. Usual occupation: Street car motorman 4

11. Industry or business: Retired 0

MOTHER FATHER

12. Name: James Moffett

13. Birthplace: No record (City, town, or county) No record (State or foreign country)

14. Maiden name: Nellie Emaline Grounds

15. Birthplace: East Lynn (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: Mrs. Bertha Ethel Moffett

(b) Address: 1919 Skiles, K.C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-17-1940 (Month) (Day) (Year)

(c) Place: burial or cremation: Harrisonville, Mo.

18. (a) Signature of funeral director: Sheil Funeral Home

(b) Address: 6606 Indep. Ave., K.C. Mo.

19. (a) Sept. 17, 1940 (Date received local registrar) (b) M. M. Crome (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 15th year 1940 hour 7:00 P. Minute ____ M.

21. I hereby certify that I attended the deceased from Aug. 1938, 19__, to death, 19__; that I last saw him alive on About three weeks ago, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Carcinoma of prostate	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 51	

Major findings: Of operations

Of autopsy: None

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)

(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? (Specify type of place)

While at work? (e) Means of injury: !

23. Signature: Duncan R. Thom (M. D. or other)

Address: Med. Dir. K.C. Gen. Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.