

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **44177**

REG. JAN 27 1940 661
Registration District No. **661**

Primary Registration District No. **6171**

Registrar's No. **41**

1. PLACE OF DEATH:

(a) County **WARREN**
(b) City or town **TRUESDALE**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Edgar Hoover Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) **2**

3. (a) PRINT FULL NAME **MARY JANE MOZIER**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife **John W. Mozier** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Nov. 21, 1878**
(Month) (Day) (Year)

8. AGE: Years **62** Months **0** Days **26** If less than one day hr. _____ min. _____

9. Birthplace **Lincoln County Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business _____

MOTHER FATHER { 12. Name **MICHAEL RAMSOUR**

13. Birthplace **Lincoln County, Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **NANCY COX**

15. Birthplace **Lincoln County Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Jane Mozier**

(b) Address **Warrenton, Mo. RFD**

17. (a) **Burial** (b) Date thereof **Dec. 19, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lincoln County Mo.**

18. (a) Signature of funeral director **F. W. Melburg & Son**

(b) Address **Warrenton, Mo.**

19. (a) **Dec. 20, 1940** (b) **at Warrenton**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **17**
year **1940** hour **2** minute _____ P. M.

21. I hereby certify that I attended the deceased from **Dec 12**, 1940, to **Dec 17**, 1940,
that I last saw him alive on **Dec 17**, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of breast** Duration **1 year**

Due to _____
Due to **50**

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) _____
(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? **86**

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

23. Signature **Charles L. Garcia** (M. D. or other) _____
Address **Warrenton, Mo.** Date signed **12/18/40**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

