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DEPART. OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

15138

DECEASED MAY 5 1943

State File No.

Registration District No. 5-3-46 94

Primary Registration District No. 94-5346

Registrar's No. 94

1. PLACE OF DEATH: **Dade**

(a) County **Dade**

(b) City or town **Rural South Morgan Twp.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2 1/2 miles N.W. of Dadeville, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **no** (Specify whether)

In this community **66 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: **29**

(a) State **Missouri** (b) County **Dade**

(c) City or town **rural**
(If outside city or town limits, write "RURAL")

(d) Street No. **2 1/2 miles N.W. of Dadeville, Mo.**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country **no**

3. (a) PRINT FULL NAME **Joseph Franklin Mote**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **No**

4. Sex **Male**

5. Color or race **white**

6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Josephine Mote**

6. (c) Age of husband or wife if alive **81** years

7. Birth date of deceased **July 18 1859**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

83 8 27 .hr. .min.

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

10. Usual occupation **Carpenter**

11. Industry or business **Building**

MOTHER FATHER { 12. Name **William Mote**

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

14. Maiden name **Margaret**

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

16. (a) Informant **Miss. Carrie Mote**

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

17. (a) **Burial** (b) Date thereof **4-16-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Dadeville, Mo**

18. (a) Signature of funeral director **Hard Funeral Home**

(b) Address **Sheffield Mo.**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **15**
year **1943** hour **10** minute **30** A. M.

21. I hereby certify that I attended the deceased from **April 12**, 1943 to **April 14**, 1943 that I last saw him alive on **April 14**, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death **Epilepsy**

Duration **3 days**

Due to **arterial sclerosis** 4/43

Due to

Other conditions **general debility**
(Include pregnancy within 3 months of death)

Major findings: Of operations **830**

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?

While at work?..... (Specify type of place)
(e) Means of injury **0**

23. Signature **B. B. Kirby** (M. D. or other) **0**

Address **Dadeville, Mo** Date signed **4-16-43**

1200 (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING 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.....
..... Registered Apprentice No.....
working under my personal supervision.

Signed *Sam E. Senseney Jr.*

Licensed Embalmer No. *4099*

P. O. Address *Greenfield Mo.*

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. 14138

Registration District No. 94

Primary Registration District No. 5346

Registrar's No. 94

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

1. PLACE OF DEATH:
 (a) County Wade
 (b) City or town Rural
(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. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Joseph F. Male
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased _____ (Month) (Day) (Year)

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

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

10. Usual occupation _____
 11. Industry of business _____

MOTHER FATHER
 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)
(Burial, cremation, or removal)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) 4/16/43 (b) Joseph F. Male
(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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1943 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____
 Due to _____
 Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

Duration _____
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 _____ (M. D. or other) _____
 Address _____ Date signed _____

S-14138