

FILED MAR 10 1944

State File No. ....

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 17

1. PLACE OF DEATH

(a) County Clay

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

(c) Name of hospital or institution 409 E. Excelsior St.  
(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)

In this community 19 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay

(c) City or town Excelsior Springs  
(If outside city or town limits, write "RURAL")

(d) Street No. 409 E. Excelsior St.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Harriett Jane Moore

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 31<sup>st</sup>  
year 1944 hour 1:30 minute 9 M.

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

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.

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

6. (b) Name of husband or wife Mitchell 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 10 1860  
(Month) (Day) (Year)

Immediate cause of death Coronary Occlusion Duration \_\_\_\_\_

8. AGE: Years 83 Months 4 Days 21 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace Oneida County New York  
(City, town, or county) (State or foreign country)

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation Housewife

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

11. Industry or business \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

12. Name Emery Wadsworth Lyman

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 Phodellal Shepard  
(b) Address Excelsior Springs Mo.

17. (a) Burial (b) Date thereof 2-2-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salem Cemetery

18. (a) Signature of funeral director C. Claude Truchard  
(b) Address Excelsior Springs Mo.

19. (a) 2-2-44 (b) Mrs. Lada Redman  
(Date received local registrar) (Registrar's signature)

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

(a) Accident, suicide, or homicide (specify) Coronary Occlusion

(b) Date of occurrence Jan. 31<sup>st</sup> 1944

(c) Where did injury occur? Excelsior Springs Clay Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
None

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury 3

23. Signature P. W. Procher (M. D. or other) \_\_\_\_\_  
Address Excelsior Springs Mo. Date signed 2-1-44

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

24  
1

24

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1166

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

3-9-44

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

*Carl Rapp*

Licensed Embalmer No.

3458

P. O. Address

*Excelsior Springs, 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.