

FILED JAN 13 1945  
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Registration District No. 2

Primary Registration District No. 4009

Registrar's No. 109

1. PLACE OF DEATH:

(a) County Andrew MO

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

(c) Name of hospital or institution: Dr. Nichols Sanatorium  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0  
(Specify whether)

In this community 0  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Andrew MO

(c) City or town Savannah MO  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Catherine Jane Taylor Moffitt

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 18  
year 1944 hour 4 minute 15 P.M.

21. I hereby certify that I attended the deceased from Oct 1944, to Dec 18 1944  
that I last saw her alive on Dec 18 1944  
and that death occurred on the date and hour stated above.

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

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

7. Birth date of deceased. Feb 15 1867  
(Month) (Day) (Year)

Immediate cause of death Cerebral Apoplexy

Due to Hypertension was treated for epithelioma on left ear. myriol stenosis.

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

8. AGE: Years 77 Months 10 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation At Home

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

MOTHER FATHER { 12. Name Joseph Taylor

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

14. Maiden name Catherine

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

16. (a) Informant Mrs. Carrie Hower

(b) Address Savannah MO

17. (a) Removal (b) Date thereof 12-23-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Inglewood calif.

18. (a) Signature of funeral director E. G. Breit

(b) Address Savannah MO

19. (a) 12-22-44 (b) J. H. Antelman  
(Date received local registrar) (Registrar's signature)

Major findings: Of operations ly3

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? \_\_\_\_\_

(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury? \_\_\_\_\_

23. Signature J. H. Antelman (M. D. or other) \_\_\_\_\_  
Address Savannah MO Date signed 12/19/44

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

2  
1  
0

7072

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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.....

*E. C. Breit*

Licensed Embalmer No. *2650*

P. O. Address *Savannah, 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.**