

S. No. 2
00M-5-43
Rev. 5-17-39
I X36871

FILED APR 2 1947

Registration District No. _____ Primary Registration District No. **3016**

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

1. PLACE OF DEATH:

(a) County Cole

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

(c) Name of hospital or institution: 1503 Franklin
(If not in hospital or institution, write street number or location)

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

In this community 60 years
years, months or days

3. (a) PRINT FULL NAME William G. Moad

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

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Mary 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased April 11 1874
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>9</u>	<u>12</u>	hr. _____ min. _____

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

10. Usual occupation Police

11. Industry or business Mo Pacific Railroad

MOTHER FATHER

12. Name Joseph Moad

13. Birthplace Jefferson N. Carolina
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Woodrow Moad

(b) Address 503 - Franklin

17. (a) Burial (b) Date thereof 3-25-47
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Samuel Surra

(b) Address 720 Jefferson

19. (a) 3-26-47 (b) R. P. Davis MD JR
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole 26

(c) City or town Jefferson City
(If outside city or town limits, write "RURAL") 5

(d) Street No. 1503 - Franklin
(If rural, give location) 1

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23
year 1947 hour 6 minute a. M.

21. I hereby certify that I attended the deceased from April 14 1946 to March 23 1947
that I last saw him alive on March 22 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis

Due to _____

Due to Arterio Sclerosis

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

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy _____

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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)

(c) Means of injury _____

23. Signature W. B. Bruce M. D. or other MD

Address W. B. Bruce Date signed Mar 28 1947

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RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 3/31/47

VS JUN 14 1960

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. 3641

P. O. Address Jmo

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.