

FILED MAY 8 1947  
274Registration District No. 274Primary Registration District No. 3052Registrar's No. 167

## 1. PLACE OF DEATH:

(a) County Pettis  
 (b) City or town Sedalia  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
1508 E. 10th  
 (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) Entire life

3. (a) PRINT FULL NAME ELNORA Mosby

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

4. Sex Female 5. Color or race white  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife George Mosby 6. (c) Age of husband or wife if alive 78 years  
 7. Birth date of deceased Aug 24 1870  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>8</u>	<u>5</u>	_____ hr. _____ min.

9. Birthplace Pettis Co Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation House wife

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

12. Name Adam Baugh13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)14. Maiden name Mary Morrison15. Birthplace Morgan Co Missouri  
(City, town, or county) (State or foreign country)16. (a) Informant Manuel Mosby(b) Address Kansas City Mo17. (a) Burial (b) Date thereof 5-1-47  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Flat Creek Cemetery18. (a) Signature of funeral director McLaughlin Bros(b) Address Sedalia, Mo19. (a) 5-1-47 (b) Betty Yeager  
(Date received local registrar) (Registrar's signature)25/8 (Licensed Embalmer's Stamp)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pettis 80  
 (c) City or town Sedalia 6  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1508 E. 10th 4  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 29  
year 1947 hour 12 minute 50 A M.21. I hereby certify that I attended the deceased from  
NOVEMBER 1946 to APRIL 29 1947  
that I last saw her alive on APRIL 29 1947  
and that death occurred on the date and hour stated above.Immediate cause of death Carcinomatosis Duration 6 months

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

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

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

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? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature Chas Gordon Beaufort (M. D. or other) MDAddress Sedalia Missouri Date signed 4/30/47

MOTHER FATHER

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

5-2-47

APR 28 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

*Philip McLaughlin*

Licensed Embalmer No.

*3429*

P. O. Address

*Seaboard, 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.

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 167

1. PLACE OF DEATH:

(a) County Pettis  
(b) City or town Sedalia  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days)

3. (a) PRINT FULL NAME Elmore Mosby  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Aug 24 (Month) (Day) (Year)

8. AGE: Years 76 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

10. Usual occupation \_\_\_\_\_

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

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) (Place: burial or cremation)

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (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 Aug year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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. Immediate cause of death \_\_\_\_\_

Primary site unknown

Due to but probably in gall bladder

Due to no autopsy granted

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

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_ H6F

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) (f) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) [Signature]  
Date signed \_\_\_\_\_

SUPPLEMENTARY

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

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