

No. 2
8-43
17-39
1-37623

FILED JUN 13 1947

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 212

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Oakwood
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Long Rest Home 43301 Market
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community 1 Year
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pike
(c) City or town Frankford
(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 June day 1
year 1947 hour 1-45 minute P.M.
21. I hereby certify that I attended the deceased from June 1
1947 to June 1, 1947
that I last saw him alive on June 1, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Hemorrhage
Due to Cerebral Arterio Sclerosis

Duration
1 week

3. (a) PRINT FULL NAME Emma Anne Mosley
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F / 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Steve Mosley 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased Dec 13 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
83 5 10 hr. min. 0

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

10. Usual occupation.....

11. Industry or business.....

12. Name Allison Jones
13. Birthplace Pike County
(City, town, or county) (State or foreign country)
14. Maiden name Catharine Todd
15. Birthplace Pike County
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs E. S. Brown
(b) Address Hannibal Mo.

17. (a) Burial (b) Date thereof June 4 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Frankford Mo

18. (a) Signature of funeral director Fields & Son

(b) Address Frankford Mo

19. (a) 6-2-47 (b) Dr E M Lucke
(Date received local registrar) (Registrar's signature)

Other conditions (include pregnancy within 3 months of death)
Major findings: Of operations GA
Of autopsy.....

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 AS Norton (M. D. or other)
Address Hannibal Mo. Date signed 6-2-47

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

MOTHER FATHER

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..... *Jane Fields Megowan*

Licensed Embalmer No. *4093*

P. O. Address. *Frankford, 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. 209 Primary Registration District No. 3043

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(a) County marion
(b) City or town Oakwood
(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

Emma A. Masley

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

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

8. AGE: Years 83 Months 5 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 _____

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) _____ (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 _____ year 1947 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 _____

Duration

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

18131