DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 12 1947

Registration District No. 294

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39278

Primary Registration District No. 3056

Registrar's No. 273

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Moberly (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: McCormick Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution six days (Specify whether years, months or days)
In this community Six Days

2. USUAL RESIDENCE OF DEACESED:
(a) State Missouri (b) County Shelby
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. RFD #1 Clarence (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME CORA MAY WESTFALL
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife F. Warren Westfall
6. (c) Age of husband or wife if alive 80 years
7. Birth date of deceased August (Month) 28 (Day) 1874 (Year)

8. AGE: Years 73 Months 3 Days 2 If less than one day ____ hr. ____ min.

9. Birthplace Vincennes (City, town, or county) Indiana (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name John Kirk
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Rozella Parr
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant's own signature F. W. Westfall
(b) Address RFD #1, Clarence, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1-47 (Month) (Day) (Year)
(c) Place: burial or cremation Phillips Cemetery
18. (a) Signature of funeral director Scott Funeral Home
(b) Address Moberly, Mo.
19. (a) Dec 1-47 (Date received local registrar) (b) Leon Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 30 year 1947 hour 1 minute 56 a. M.
21. I hereby certify that I attended the deceased from Nov. 25 1947 to Nov. 30 1947 that I last saw her alive on Nov. 30 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of uterus & adenexa — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death) HB
Major findings: Of operation Carcinoma involving genital organs.
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature H. L. McCormick (M. D. or other) M.D.
Address Moberly Mo Date signed 12-1-47

(Licensed Embalmer's Statement on Reverse Side)

Rev. 3-1-46 I X19511

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

RECEIVED
District Health Officer No. 10
District File Number 12-47-171
Date Filed DEC 1 3 1947

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~~ C. H. Hutton, Registered Apprentice No. 10, working under my personal supervision.

Signed R. M. Cater

Licensed Embalmer No. 4117

P. O. Address Moberly 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, above space should be left blank.