

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36045**

FILED DEC 7 1948

Registration District No. **79**

Primary Registration District No. **3379**

Registrar's No. **64**

1. PLACE OF DEATH:

(a) County **DeKalb**  
(b) City or town **Amity Rural Sherman**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Home**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **18 Months**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) County **DeKalb**  
(b) City or town **Amity Rural**  
(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

**Agnes W. Moody**  
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 **Emery D. Moody** 6. (c) Age of husband or wife if alive **66** years  
7. Birth date of deceased **Dec. 14, 1882**  
(Month) (Day) (Year)

8. AGE: Years **76** Months **12** Days **14**  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **Lagrange Ill.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

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

MOTHER FATHER

12. Name **W. O. Whipple**  
13. Birthplace **Mo.**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Martha Coughenor**  
15. Birthplace **Mo.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Karl Lawson**  
(b) Address **Amity Mo.**

17. (a) **Burial** (b) Date thereof **Nov. 12-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Maysville Mo.**

18. (a) Signature of funeral director **[Signature]**  
(b) Address **Maysville Mo.**  
19. (a) **11-14-48** (b) **Roscoe Savelley**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **9**  
year **1948** hour **7** minute **10 P.M.**

21. I hereby certify that I attended the deceased from **July**, 1947, to **Nov 9**, 1948  
that I last saw her alive on **Nov 9**, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death  
**Cerebral Thrombosis** 5 days  
Due to **Cerebral Hemorrhage** 2 years

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy **[Signature]**

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 **2**  
23. Signature **[Signature]** (M.D. or other) **[Signature]**  
Address **Maysville Mo.** Date signed **11-10-48**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SEP 16 1950  
HEALTH OFFICE  
Cameron, Mo.

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

*John Brann*

Licensed Embalmer No. 3933

P. O. Address

*Waysville, 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.