FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 29 1948

Registration District No. 31

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4640

State File No. 39322

Registrar's No. 37

1. PLACE OF DEATH:
(a) County Benton
(b) City or town Cole Camp (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Moreland Clinic 0 (If not in hospital or institution, write street, number or location)
(d) Length of stay: In hospital or institution 13 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Benton 8
(c) City or town Mora 0 (If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Walter Scott Moffett
3. (b) If veteran, name war None
3. (c) Social Security No. 492 14 6974
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed 2
6. (b) Name of husband or wife Maude Elliott
6. (c) Age of husband or wife if alive Deceased
7. Birth date of deceased July (Month) 25 (Day) 1871 (Year)

8. AGE: Years 77 Months 4 Days 25 If less than one day hr. min.

9. Birthplace Shelby County (City, town, or county) Missouri (State or foreign country) 6
10. Usual occupation Carpenter (Retired)
11. Industry or business
FATHER
12. Name Robert A. Moffett 0
13. Birthplace Unknown (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name Martha Taylor
15. Birthplace Unknown (City, town, or county) Kentucky (State or foreign country)
16. (a) Informant Mrs. Mora Stearman
(b) Address Mora, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-48 (Month) (Day) (Year)
(c) Place: burial or cremation Windsor, Missouri
18. (a) Signature of funeral director Huston-Turner
(b) Address Windsor, Missouri
19. (a) 12-23-1948 (Date received local registrar) (b) E. L. Eickhoff (Registrar's signature) 37

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 20 year 48 hour 6 minute 15 P M

21. I hereby certify that I attended the deceased from 12-7-48, 19..., to 12-20-48, 19...; that I last saw him alive on 12-20-48, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocardial Failure	
Due to: Intestinal Obstruction	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

122 B

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN
Underline the cause of 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) 2
While at work? (e) Means of injury

23. Signature R. W. Moreland (M. D. or other) DO
Address Cole Camp, Mo Date signed 12-20-48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK

RECEIVED
District Health Officer No.
District Reg. Number 11-48-149
Date Filed 12-28-48

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 William M. Turner, Registered Apprentice No. 470, working under my personal supervision.

Signed Elden M. Hunter

Licensed Embalmer No. 3391

P. O. Address Windsor 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.

B
45
3880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan 37

Registration District No. 31 Primary Registration District No. 4040 Registrar's No. 37

1. PLACE OF DEATH:

(a) County Benton

(b) City or town Cole Camp
(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)
In this community

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

3. (a) PRINT FULL NAME Walter S. Moffett

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 Wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive

7. Birth date of deceased July 25 (Month) (Day) (Year)

8. AGE: Years 77 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) No (State or foreign country)

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. Day 2 year 1948 hour minute M.

21. I hereby certify that I attended the deceased from 19..., 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 Strangulation of distal end of Ileum (Intestinal obstruction)

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature G. W. Moreland (M. D. or other) MD

Address Cole Camp, Mo Date signed 1-4-49

SUPPLEMENTARY

39322