

No. 2
1-147
5-17-39

FILED DEC 20 1948

Registration District No. **12**

Primary Registration District No. **1000**

Registrar's No. **1335**

1. PLACE OF DEATH:

(a) County: **Buchanan**

(b) City or town: **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Missouri Methodist Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: **26 days**
(Specify whether In this community: **26 days** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Kansas** (b) County: **Doniphan 999**

(c) City or town: **Wathena, Mo**
(If outside city or town limits, write "RURAL")

(d) Street No. **11**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No) **2**
If yes, name country:

3. (a) PRINT FULL NAME: **MATILDA KATHERINE MOSKAU**

3. (b) If veteran, name war: **No**

3. (c) Social Security No.: **None**

4. Sex: **Female** 5. Color or race: **White** 6. (a) Single, widowed, married, divorced: **Widow 2**

6. (b) Name of husband or wife: **Theodore Moskau** 6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased: **Feb. 14, 1867**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	81	9	25	hr. _____ min. _____

9. Birthplace: **Wathena, Kansas**
(City, town, or county) (State or foreign country)

10. Usual occupation: **Housewife**

Own Home

11. Industry or business:

12. Name: **Daniel Hoffman** **4**

13. Birthplace: **Unknown Germany**
(City, town, or county) (State or foreign country)

14. Maiden name: **Elizabeth Tanner** **5**

15. Birthplace: **Unknown Switzerland**
(City, town, or county) (State or foreign country)

16. (a) Informant: **Dan Moskau**

(b) Address: **Wathena, Kansas**

17. (a) **Removal** (b) Date thereof: **12/10/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Wathena Kansas**

18. (a) Signature of funeral director: **Emma Clark**

(b) Address: **120 Illinois Ave. St. Joseph, Mo.**

19. (a) **12-14-48** (b) **L. S. Jenkins**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: **Dec.** day: **9** year: **1948** hour: **9** minute: **30** p. **M.**

21. I hereby certify that I attended the deceased from **11-15-48** to **12-9-48** that I last saw him alive on **12-9-48** and that death occurred on the date and hour stated above. **12-9-48** Duration:

Immediate cause of death: **fracture of Right femur** **3 weeks**

Due to: **fall-**

Due to:

Other conditions: **diabetes mellitus** **4 years**
(include pregnancy within 3 months of death)

Major findings: **10/18**

Of operations:

Of autopsy:

PHYSICIAN: _____

Underline the cause of which death should be charged statistically.

22. -If death was due to external causes, fill in the following: **ADDITIONAL SUPPLEMENTARY INFORMATION / 31**

(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)

23. Signature: **J. H. Tragan** (M. D. or other) **mo.**

Address: **420 N. 8th** Date signed: **12-10-48**

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

MOTHER FATHER

DEC 20 1948

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.....

..... *B. J. Chaney* Registered Apprentice No. *294*
working under my personal supervision.

Signed..... *Emma Clark*

Licensed Embalmer No. *4238*

P. O. Address..... *St Joseph 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. 42

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(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 matilda K. maskau

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

4. Sex F 5. Color of 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 7 14 18
(Month) (Day) (Year)

8. AGE: Years 81 Months _____ Day _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country) Kansas

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)

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 _____ Day _____
year 1948 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) accident.
(b) Date of occurrence Nov 14, 1948
(c) Where did injury occur? W. Meena Kansas
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
home

While at work? No (Specify type of place) (e) Means of injury fall

23. Signature John P. Ferguson (M. D. or other)

Address 420 N. 83 St Date signed 12-23-48

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

SUPPLEMENTARY

S-39417