

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18640

State File No.

FILED MAY 25 1953

BIRTH NO. _____		REG. DIST. NO. <u>187</u>		PRIMARY REG. DIST. NO. <u>3040</u>		Registrar's No. <u>12</u>	
1. PLACE OF DEATH a. COUNTY <u>Livingston</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Chillicothe</u>		c. LENGTH OF STAY (in this place) <u>8 mos</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Chillicothe</u>		<u>1592</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1115 Fair</u>				d. STREET ADDRESS (If rural, give location) <u>1115 Fair</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>NELLIE</u>		b. (Middle) <u>H.</u>		c. (Last) <u>MOSSBARGER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5-15-53</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1-14-1886</u>	9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months	IF UNDER 14 HRS. Days	IF UNDER 14 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>James E. Harris</u>		13b. MOTHER'S MAIDEN NAME <u>Lucy Hollier</u>		14. NAME OF HUSBAND OR WIFE <u>S. L. Mossbarger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Bertha Farrar, Laclede Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Intestinal obstruction</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Post Operative Hernia 5 years</u> DUE TO (c) <u>Obesity</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		<u>287x</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 1, 1952</u> , to <u>May 15, 1953</u> , that I last saw the deceased alive on <u>May 15, 1953</u> , and that death occurred at <u>12:15 pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>D. Collier</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>Chillicothe Mo</u>		23c. DATE SIGNED <u>May-16-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>5-17-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Laclede Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Laclede Mo.</u>		
DATE REC'D BY LOCAL REG. <u>May-16-53</u>		REGISTRAR'S SIGNATURE <u>Trance B. Neel</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Brothers</u>		ADDRESS <u>Laclede Mo.</u>	

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

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed W. R. Winger

Licensed Embalmer No. 4655

P. O. Address Laurel, Md.

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.