

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.

JAN 13 1940

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

42378  
Do not use this space.

1. PLACE OF DEATH  
 (a) County JACKSON Registration District No. 399  
 (b) Township Kaw Primary Registration District No. 1002  
 (c) City KANSAS CITY (d) Street No. ST LUKE'S HOSPITAL Registered No. 4787  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 200 Thomas A Moxcey  
 (a) Residence, No. 603 NORTH 4th ST. St.  ATCHISON, KANSAS  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ida

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 5, 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
66 7 12

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. LAWYER  
 9. Industry or business in which work was done, as saw mill, bank, etc. OFFICE  
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Atchison Kansas

FATHER 13. NAME Samuel C. Moxcey  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

MOTHER 15. MAIDEN NAME Katherine McInerney  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT (ADDRESS) Ida Steiner Moxcey  
Atchison Kansas

18. BURIAL, CREMATION, OR REMOVAL PLACE Atchison Mo DATE Dec 19 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) R. H. Fulton  
Kansas City Kansas

20. FILED Dec. 18, 1939 M. M. Craue  
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) DEC., 17 1939

22. I HEREBY CERTIFY, That I attended deceased from OCT., 2, 1939, to DEC., 17, 1939  
 I last saw him alive on DEC., 17, 1939. Death is said to have occurred on the date stated above, at 1:40 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Stroke  
Business Interruption  
95%

Other contributory causes of importance:  
Hypertension  
Arteriosclerosis

Name of operation NONE Date of None  
 What test confirmed diagnosis? Chlorine Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? Date of injury....., 19.....  
 Where did injury occur? (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify (Signed) H. P. Armstrong M. D.  
 (Address) 1116 Prof. Bldg. R.C. 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

*M. M. Sevens*

Licensed Embalmer No. *3505*

P. O. Address *K. E. Kausser*

**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.**