No. 2
—9-4-41
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 5367

FILED FEB 27 1943

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 641

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Luke Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 hrs (Specify whether years, months or days) In this community 12 years

2. USUAL RESIDENCE OF DEACESED: 999
(a) State: Kansas (b) County: Johnson 14
(c) City or town: Olathe (If outside city or town limits, write "RURAL") 0
(d) Street No.: R. F. D. (If rural, give location)
(e) Citizen of foreign country? ~~yes~~ (Yes or No)
If yes, name country: 2

3. (a) PRINT FULL NAME: Joseph W. Moll
3. (b) If veteran, name war: no
3. (c) Social Security No.: None
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband ~~or wife~~: Mrs. Teresa Moll
6. (c) Age of husband or wife if alive: unk years
7. Birth date of deceased: December 31, 1878 (Month) (Day) (Year)

8. AGE: Years 64 Months 1 Days 65 If less than one day hr. min.

9. Birthplace: Olathe (City, town, or county) Kansas (State or foreign country)
10. Usual occupation: Farmer.
11. Industry or business:
MOTHER FATHER
12. Name: Henry Moll
13. Birthplace: Ill. (City, town, or county) (State or foreign country)
14. Maiden name: Emma M. Moll
15. Birthplace: Ill. (City, town, or county) (State or foreign country)
16. (a) Informant: Hospital Records
(b) Address: St Luke Hosp 19-C. Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-7-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Olathe, Kans.
18. (a) Signature of funeral director: M. L. Ferguson
(b) Address: Olathe, Kansas
19. (a) 643 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 6 year 43 hour 11 minute 30 P.M.
21. I hereby certify that I attended the deceased from Pathologist, to _____, 19____; that I last saw h_____ alive on _____, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Obstruction of colon with paralytic ileus	5 days
Due to: Kinks in splenic flexure	
Due to: 1222B	
Other conditions (Include pregnancy within 3 months of death): Passive congestion 2 lung	

Major findings:
Of operations:
Of autopsy: Obstruction of splenic flexure of colon.

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: J. H. Haskins D. (M. D. ~~or other~~)
Address: 1310 Prof. Bldg. K.C. Mo. Date signed 2-7-43

(Licensed Embalmer's Statement on Reverse Side)

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 Martin W Frye, Registered Apprentice No. ....., working under my personal supervision.

Signed Martin W Frye

Licensed Embalmer No. 3615

P. O. Address Olathe, Kansas

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.