

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED OCT 24 1944

Registration District No. 797

Primary Registration District No. 1002

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

**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:  
4925 Michigan 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community 18 years  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Jackson 48  
 (c) City or town Kansas City 2  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 4925 Michigan 8  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Joseph Denton Moore  
 3. (b) If veteran, name war no 3. (c) Social Security No. none  
 4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced single  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased August 24th 1926  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month October day 3rd  
 year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from Jan. 4 1943, to present 19\_\_\_\_;  
 that I last saw him alive on day 1944;  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>18</u>	<u>1</u>	<u>9</u>	hr. _____ min. _____

Immediate cause of death Myocardial Infarct  
 Duration 18 hrs  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions No 1565  
(Include pregnancy within 3 months of death)

9. Birthplace Kansas City, Missouri  
(City, town, or county) (State or foreign country)  
 10. Usual occupation at home

Major findings:  
 Of operations No  
 Of autopsy \_\_\_\_\_  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
 12. Name Walter N. Moore  
 13. Birthplace Kansas City, Missouri  
(City, town, or county) (State or foreign country)  
 14. Maiden name Grace Waggener Moore  
 15. Birthplace Kansas City, Missouri  
(City, town, or county) (State or foreign country)  
 16. (a) Informant Walter N. Moore  
 (b) Address 4925 Michigan Avenue  
 17. (a) Burial (b) Date thereof 10-5-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Forest Hill Cemetery  
 18. (a) Signature of funeral director Freeman Mortuary  
 (b) Address Kansas City, Mo.  
 19. (a) 10-3-44 (b) J. E. Brown  
(Date received local registrar) (Registrar's signature)

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?  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 0  
 23. Signature E. T. Gethman M.D. (M. D. or other)  
 Address 1728 Prof. Rd., Kansas City, Mo. Date signed 10/3/44

Mr. E. J. ...  
1130-2 pm

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

*James E. P. ...*

Licensed Embalmer No. 481

P. O. Address A. C. 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.**