

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2181

**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:  
4437-WAYNE AVENUE 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 50 YEARS  
years, months or days)

3. (a) PRINT FULL NAME MR. ADAM EDWIN MOSER  
 (b) If veteran, name war No  
 3. (c) Social Security No. 705-18-845  
 4. Sex MALE 5. Color or race WHITE  
 6. (a) Single, widowed, married, divorced MARRIED  
 6. (b) Name of husband or wife MRS. FRANCES V. MOSER  
 6. (c) Age of husband or wife if alive 57 years  
 7. Birth date of deceased JUNE 23 1876  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>10</u>	<u>20</u>	hr. _____ min.

9. Birthplace BOONESBOROUGH MISSOURI  
(City, town, or county) (State or foreign country)  
 10. Usual occupation PULLMAN CONDUCTOR  
 11. Industry or business 30 YEARS  
 12. Name WINYOWN MOSER  
 13. Birthplace unknown  
(City, town, or county) (State or foreign country)  
 14. Maiden name MARTHA  
 15. Birthplace unknown  
(City, town, or county) (State or foreign country)

**MOTHER FATHER**  
 16. (a) Informant MRS. FRANCES V. MOSER  
 (b) Address 4437-WAYNE AVENUE  
 17. (a) BURIAL (b) Date thereof MAY 16 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation WARRENSBURG, MO.  
 18. (a) Signature of funeral director D. H. Newcomer's Sons  
 (b) Address 1401 BAUSH CREEK BLVD.  
 19. (a) 5-15-46 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State MISSOURI (b) County JACKSON  
 (c) City or town KANSAS CITY  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 4437-WAYNE AVENUE  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 DATE OF DEATH: Month MAY day 13<sup>TH</sup>  
 year 1946 hour 2 minute 55 M.  
 I hereby certify that I attended the deceased from SEPT., 1920, to MAY 13, 1946  
 that I last saw him alive on MAY 12 11 PM, 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death ANGINA PECTORIS  
 Due to Coronary sclerosis  
 Due to Hypertension  
 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.

21. 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 \_\_\_\_\_  
 23. Signature J. L. Lane (M.D. or other) DO  
 Address 3 E 39 Date signed 5/14-46

**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 Melvin Miller

Licensed Embalmer No. 4407

P. O. Address Kansas City, 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2181

1. PLACE OF DEATH:

(a) County Jackson Co.  
 (b) City or town Hansasi City  
 (c) Name of hospital or institution: 4437 Wayne  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 years, months or days)

3. (a) PRINT FULL NAME Adam Edwin Moser

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 208-18-8458

5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

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) 5-15-46 (Date received local registrar) (b) Steraldine Holm (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 \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 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) \_\_\_\_\_

(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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

10768