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MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **40281**

FILED DEC 29 1948

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **5087**

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:
OSTEOPATHIC HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **11 HOURS**.
In this community **4 DAYS**.
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **ILLINOIS** (b) County **999**

(c) City or town **EAST ST. LOUIS**
(If outside city or town limits, write "RURAL")

(d) Street No. **2313 NORTH 57TH STREET 2**
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **MRS. BESSIE R MOUREY**

3. (b) If veteran, name war **NO**

3. (c) Social Security No. **NONE**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DECEMBER** day **14TH**
year **1948** hour **2** minute **40** A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

4. Sex **FEMALE**

5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **WIDOWED**

(b) Name of husband or wife **MR. CHARLES W. MOUREY**

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **DECEMBER 19 1869**
(Month) (Day) (Year)

Immediate cause of death **Coronary Sclerosis** Duration _____

8. AGE: Years **28** Months **11** Days **26** 25 If less than one day
hr. min.

Due to _____

Due to _____ **9 30**

9. Birthplace **MONTGOMERY COUNTY, MISSOURI**
(City, town, or county) (State or foreign country)

Other conditions (Include pregnant within 3 months death) _____

Major findings: **Deputy Coroner** PHYSICIAN

10. Usual occupation **AT HOME**

Of operations _____

Of autopsy **See Above**

11. Industry or business _____

12. Name **WILLIAM RUE**

13. Birthplace **PENNSYLVANIA**
(City, town, or county) (State or foreign country)

14. Maiden name **HARRIETTE A. COYLE**

15. Birthplace **WEST VIRGINIA**
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS. BESSIE DE TALENTE**

(b) Address **HICKMAN MILLS, MISSOURI**

17. (a) **REMOVAL** (b) Date thereof **DEC-15-1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **EAST ST. LOUIS, ILLINOIS**

18. (a) Signature of funeral director **D. W. Newcome, Sons**

(b) Address **1401 Brush Creek Blk.**

19. (a) **12-14-48** (b) **Steradine Home**
(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? _____

A. **E. Upsher** (Specify type of place) _____

While at work _____ Means of injury _____

23. Signature **E. Upsher** (M.D. or other) _____
Address **2800 Main** Date signed **12/14/48**

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

MOTHER FATHER

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..... *Bernard L. Gloran*.....

Licensed Embalmer No..... *4250*.....

P. O. Address..... *W.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.