

FILED FEB 4 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1355

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>177</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>Jackson</u>		b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>Jackson</u>	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Brookside Hotel, 54th & Brookside</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		d. STREET ADDRESS (If rural, give location) <u>54th & Brookside</u>	
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH			5. SEX	
a. (First) <u>Benjamin</u>	b. (Middle) <u>Franklin</u>	c. (Last) <u>Moats</u>	Month <u>January</u>	Day <u>12</u>	Year <u>1949</u>	Male <input checked="" type="checkbox"/>	Female <input type="checkbox"/>
6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>March 5, 1865</u>		9. AGE (In years last birthday) (If under 1 year: Months Days; If under 12 mos.: Hours Min.) <u>83</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Investments</u>		11. BIRTHPLACE (State or foreign country) <u>Galia County, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13a. FATHER'S NAME <u>John W. Moats</u>		13b. MOTHER'S MAIDEN NAME <u>Malinda Prose</u>		14. NAME OF HUSBAND OR WIFE <u>Mary W. Moats</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mary W. Moats, Brookside Hotel</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		<p align="center">MEDICAL CERTIFICATION</p> <p align="center">I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u></p> <p align="center">ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u></p> <p align="center">DUE TO (b) <u>High tension Cardiovascular disease</u></p> <p align="center">DUE TO (c) <u>420.1</u></p> <p align="center">II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u></p>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>0</u>			
22. I hereby certify that I attended the deceased from <u>Mar. 1943</u> , 19 <u>43</u> , to <u>Jan. 1949</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Jan 12, 1949</u> , and that death occurred at <u>5:30A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>D. R. Black</u>				23b. ADDRESS <u>924 Professional Bldg.</u>		23c. DATE SIGNED <u>1/14/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>January 15, 1949</u>		<u>Forest Hill Cemetery</u>		<u>Kansas City Missouri</u>	
DATE REC'D BY LOCAL REG. <u>1-14-49</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>WILKS FUNERAL HOME 2315 Linwood Blvd.</u>			

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

(Licensed Embalmer's Statement on Reverse Side)

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

200 40 200
10 10 48

1. PLACE OF DEATH COUNTY _____ STATE _____		2. SEX _____	
3. NAME OF DECEASED (Last, first, middle initial) _____		4. COLOR OF HAIR _____	
5. DATE OF DEATH (Month, day, year) _____		6. DATE OF BIRTH (Month, day, year) _____	
7. USUAL RESIDENCE (Address, city, state, county) _____		8. OCCUPATION, TRADE, BUSINESS OR INDUSTRY _____	
9. NAME OF MOTHER'S MARRIAGE _____		10. USUAL OCCUPATION OF DECEASED _____	
11. NAME OF MARRIAGE OR RITE _____		12. SOCIAL SECURITY NUMBER _____	
13. ADDRESS _____		14. MEDICAL CERTIFICATION (To be filled in by physician or other qualified person) _____	

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 _____

working under my personal supervision.

Signed _____ Student-Embalmer No. _____
 Signed *Chas. E. Wells* Licensed Embalmer No. *2649*
 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.)

15. DATE RECORDED BY LOCAL HEALTH DEPARTMENT _____	16. SIGNATURE OF LOCAL HEALTH DEPARTMENT OFFICER _____
17. DATE REMOVED FROM BURIAL CHAMBER _____	18. SIGNATURE OF REMOVAL OFFICER _____

MISSOURI DEPARTMENT OF HEALTH - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH