

FILED MAY 19 1949

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **16046**  
Registrar's No. **1813**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **002**

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>	
c. LENGTH OF STAY (in this place) <b>33 MIN. LIFE</b>		d. STREET ADDRESS (If rural, give location) <b>3260 Holmes</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>General Hospital No. 1</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Robert</b>	b. (Middle) <b>R.</b>	c. (Last) <b>Moser</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>4 22 49</b>
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5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>4-20-1886</b>	9. AGE (In years last birthday) <b>63</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OWNER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>WARRANTED POLISH CO.</b>	11. BIRTHPLACE (State or foreign country) <b>KANSAS CITY, MO</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>ROBERT MOSER</b>	13b. MOTHER'S MAIDEN NAME <b>MARY WAGONER</b>	14. NAME OF HUSBAND OR WIFE <b>MARIE G. MOSER</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>---</b>	16. SOCIAL SECURITY NO. <b>---</b>	17. INFORMANT'S SIGNATURE OR NAME <b>FRANCIS H. MOSER, 5825 HOLMES ST., K.C., MO</b>	ADDRESS
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>75 Min.</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>4201</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **4-22, 1949**, to **4-22, 1949**, that I last saw the deceased alive on **4-22, 1949**, and that death occurred at **12 NOON**, from the causes and on the date stated above.

23a. SIGNATURE <b>Wm. W. Hart</b> (Degree or title)	23b. ADDRESS <b>Med. Dir. General Hospital No. 1</b>	23c. DATE SIGNED <b>4-23-49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>April 26-1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>FOREST HILL</b>	24d. LOCATION (City, town, or county) (State) <b>KANSAS CITY, MISSOURI</b>
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DATE REC'D BY LOCAL REG. <b>4-25-49</b>	REGISTRAR'S SIGNATURE <b>Shiraldine Holmes</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Thuesen</b>	ADDRESS <b>Southern, K.C., Mo</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*Bernard J. Horan*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

*41250*

P. O. Address \_\_\_\_\_

*H. C. 1116*

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.