

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41430

State File No. \_\_\_\_\_

FILED JAN 4 1950

BIRTH NO. _____		REG. DIST. NO. 150		PRIMARY REG. DIST. NO. 5572		Registrar's No. 193	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Prairie		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Greenwood		48	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jackson County Hosp.				d. STREET ADDRESS (If rural, give location) Gendel			
3. NAME OF DECEASED (Type or Print) a. (First) Mary			b. (Middle)			c. (Last) Moore	
4. DATE OF DEATH Dec 11, 1949		5. SEX Female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH Feb. 6, 1858		9. AGE (In years last birthday) 91		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home			10b. KIND OF BUSINESS OR INDUSTRY Home			11. BIRTHPLACE (State or foreign country) Louisville Ky	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Will Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Vernis Aere Lees Summit Mo			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cassinova Urinary Bladder  ANTECEDENT CAUSES DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-26, 1949, to 12-11, 1949, that I last saw the deceased alive on 12-10, 1949, and that death occurred at 9:00 a.m., from the causes and on the date stated above.							
23a. SIGNATURE Frank E. Trehan, M.D. (Degree or title)				23b. ADDRESS R# 4 Independence Mo		23c. DATE SIGNED 12-13-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/13/49		24c. NAME OF CEMETERY OR CREMATORY Lees Summit		24d. LOCATION (City, town, or county) (State) Lees Summit Mo	
DATE REC'D BY LOCAL REG. DEC. 14, 1949		REGISTRAR'S SIGNATURE Donald C. Sammons 378		25. FUNERAL DIRECTOR'S SIGNATURE W. Langford		ADDRESS Lees Summit Mo	

WRITE MAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEC 29 1949

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

*W. B. Langford*  
\_\_\_\_\_  
Licensed Embalmer No. *3833*  
P. O. Address \_\_\_\_\_

Signed \_\_\_\_\_  
Student Embalmer

**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.