

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

33160

State File No.

FILED NOV 13 1950

BIRTH NO. _____ REG. DIST. NO. 112 PRIMARY REG. DIST. NO. 5428 Registrar's No. 38

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural- Boone</u>	c. LENGTH OF STAY (In this place) <u>6 Months</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural- Boone</u> <u>0360</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Boone Twp.</u>		d. STREET ADDRESS (If rural, give location) <u>Boone Twp.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Linda</u>	b. (Middle) <u>Diane</u>	c. (Last) <u>Moss</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 13 1950</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Child</u>	8. DATE OF BIRTH <u>June 30 1947</u>	9. AGE (In years last birthday) <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>13</u>	IF UNDER 2 HRS. Hour <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>	11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Oliver Moss</u>	13b. MOTHER'S MAIDEN NAME <u>Lorraine Maston</u>	14. NAME OF HUSBAND OR WIFE <u>Oliver Moss</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>Child</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Oliver Moss</u> <u>7101 Lynndover, Maplewood, Mo</u>	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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>28124</u> <u>25</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Accidentally Struck by the rear wheel of truck and run over.</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u>Fractured Skull</u>		
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"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Boone Twp. road</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Boone Twp. Franklin Mo.</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>Oct 13 1950 8:15 a.m.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR <u>Accidentally</u>
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Miss. P. Shaffer Coroner</u> (Degree or title)	23b. ADDRESS <u>65 N. Clark Ave. Sullivan, Mo.</u>	23c. DATE SIGNED <u>10-13-50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10-16-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Cave Spring Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Boone Twp. Franklin Mo.</u>
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DATE REC'D BY LOCAL REG. <u>10-16-50</u>	REGISTRAR'S SIGNATURE <u>J. L. Matthews</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Miss. P. Shaffer</u>	ADDRESS <u>Sullivan, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

10. 300
0. 48
60

File No. _____
DISTRICT HEALTH OFFICE No. 4

NOV 9 - 9 1950

RECEIVED

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 _____

Allen C. McFadden

Signed _____

Student Embalmer

Licensed Embalmer No. *4543*

P. O. Address *Sullivan, 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.