

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **40440**

**FILED JAN 8 1951**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **5466** Registrar's No. **2043**

**1. PLACE OF DEATH**

a. COUNTY **Greene**

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **Springfield, Rural, S. Campbell Twp**

c. LENGTH OF STAY (If in this place) **Life**

d. FULL NAME OF HOSPITAL OR INSTITUTION **3107 W. Grand**

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).

a. STATE **Missouri** b. COUNTY **Greene**

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **Springfield, Rural, S. Campbell Twp**

d. STREET ADDRESS (If rural, give location) **3107 W. Grand 0390**

**3. NAME OF DECEASED**

a. (First) **John** b. (Middle) **Allen** c. (Last) **Moses**

4. DATE OF DEATH (Month) (Day) (Year) **Dec. 24, 1950**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, **Never married** 8. DATE OF BIRTH **March 4, 1948**

9. AGE (In years last birthday) **2** 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) **Infant**

10b. KIND OF BUSINESS OR INDUSTRY **Infant**

11. BIRTHPLACE (State or foreign country) **Turner, Missouri**

12. CITIZEN OF WHAT COUNTRY? **USA**

13a. FATHER'S NAME **Lawrence Allen Moses** 13b. MOTHER'S MAIDEN NAME **Cora F. Perkins** 14. NAME OF HUSBAND OR WIFE **X**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **No No**

16. SOCIAL SECURITY NO. **No**

17. INFORMANT'S SIGNATURE OR NAME **Mrs. Pearl Robertson Spfld, Mo.** ADDRESS

**18. CAUSE OF DEATH** Enter only one cause per line for (a), (b), and (c)

**1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\*(a)** *Acute Bronchopneumonia*

**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.

**19a. DATE OF OPERATION** **19b. MAJOR FINDINGS OF OPERATION**

**20. AUTOPSY?** YES  NO

**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**  **NOT WHILE AT WORK**

**21f. HOW DID INJURY OCCUR?**

**22. I hereby certify that I attended the deceased from 12-24-50, 19, to 12-24-50, 19, that I last saw the deceased alive on 12-24-50, 19, and that death occurred at 6 P. m., from the causes and on the date stated above.**

**23a. SIGNATURE** *E. J. Schwartz M.D.* (Degree or title) **23b. ADDRESS** *609 Cherry, Springfield Mo.* **23c. DATE SIGNED** *12-26-50*

**24a. BURIAL, CREMATION, REMOVAL (Specify)** **Burial** **24b. DATE** *12/27/50* **24c. NAME OF CEMETERY OR CREMATORY** **EAST LAWN** **24d. LOCATION** (City, town, or county) (State) **Near Springfield, Mo.**

**DATE REC'D BY LOCAL REG.** *12-26-50* **REGISTRAR'S SIGNATURE** *W. E. Handley* **25. FUNERAL DIRECTOR'S SIGNATURE** **H. H. Lohmeyer** **ADDRESS** **Springfield, Mo.**

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

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JAN 29 1950

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.

Student Embalmer No.....

Signed.....

*Paul Johnson*

Signed.....  
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

*4734  
Springfield, 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.