

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16207

5. No. 300
V. 10.48

FILED JUN 11 1951

BIRTH NO. 36491-51 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 506

0396

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

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>GREENE</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Republic, RURAL</u>		0396	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>			d. STREET ADDRESS (If rural give location) <u>Rural Route 0</u>			
3. NAME OF DECEASED (Type or Print) (a. (First) (b. (Middle) (c. (Last)) <u>(died UNNAMED) MOONEYHAM</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 5 1951</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED/NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>6-4-1951</u>	9. AGE (In years last birthday) IF UNDER 1 YEAR <u>—</u> Months <u>—</u> Days	IF UNDER 1 HR. Hours <u>—</u> Mins. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>OMER MOONEYHAM</u>		13b. MOTHER'S MAIDEN NAME <u>Shirley Paris</u>		14. NAME OF HUSBAND OR WIFE <u>✓</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>✓</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>OMER MOONEYHAM, Republic, Mo</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, ashenia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiocirculatory collapse</u> 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.			INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u>
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) <u>7544</u>			
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 <u>June 4, 1951</u> , to <u>June 5, 1951</u> , that I last saw the deceased alive on <u>June 5, 1951</u> , and that death occurred at <u>9:00 a.m.</u> , from the causes and on the date stated above.						
23a. SIGNATURE (Degree or title) <u>Karl A. Leichinger, Jr. M.D.</u>			23b. ADDRESS <u>Republic, Mo</u>		23c. DATE SIGNED <u>6-5-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>6-6-1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>WADE Chapel</u>	24d. LOCATION (City, town, or county) (State) <u>Republic, Mo</u>			
DATE REC'D BY LOCAL REG. <u>6-6-51</u>	REGISTRAR'S SIGNATURE <u>W. S. Handley</u>		FEDERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>Gene Hunter Republic, Mo</u>			

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.

Not Embalmed

Signed *Gene Hunter*

Signed _____
Student Embalmer

Licensed Embalmer No. _____

P. O. Address _____

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.