No. 300
10.48

FILED DEC 20 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42376

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 5408

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): KANSAS CITY
c. LENGTH OF STAY (In this place): 70 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2015 Askew

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY: JACKSON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): KANSAS CITY
d. STREET ADDRESS (If rural, give location): 2015 ASKEW 3320

3. NAME OF DECEASED (Type or Print)
a. (First): DELIA
b. (Middle): H
c. (Last): MOSEE

4. DATE OF DEATH (Month) (Day) (Year): DEC 7 1952

5. SEX: FEMALE
6. COLOR OR RACE: Col.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOW
8. DATE OF BIRTH: July 14-1876
9. AGE (In years last birthday): 76 — 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): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): PARIS KINTUCKY
12. CITIZEN OF WHAT COUNTRY?: U.S.A

13a. FATHER'S NAME: HENDERSON LEWIS
13b. MOTHER'S MAIDEN NAME: ADLINE
14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT'S SIGNATURE OR NAME: William A Gordon
ADDRESS: 1612-EUCLID

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) ACUTE CARDIAC FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) LOBAR PNEMONIA ACUTE — 2 DAY
DUE TO (c) SENILITY

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

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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) m.
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* DEC. 6, 1952, *to* DEC. 6, 1952, *that I last saw the deceased alive on* DEC. 6, 1952, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: E. F. Walls (Degree or title) DO
23b. ADDRESS: 1118 E 12
23c. DATE SIGNED: 12-9-52

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 12/11/52
24c. NAME OF CEMETERY OR CREMATORY: HIGHLAND CEMATORY
24d. LOCATION (City, town, or county) (State): Kansas City, Mo.

DATE REC'D BY LOCAL REG.: 12-10-52
REGISTRAR'S SIGNATURE: Geraldine Smith
25. FUNERAL DIRECTOR'S SIGNATURE: S. F. Ramsey
ADDRESS: K.C. Mo

(Licensed Embalmer's Statement on Reverse Side)

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.

Student .....
Student Embalmer

Signed L. F. Ramsey

Licensed Embalmer No. 4081

P. O. Address 1819-E TRUMAN Rd

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.