

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9991**
1265

FILED MAR 27 1953

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

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Kansas b. COUNTY Wyandotte	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (In this place) About 2 Hrs		d. STREET ADDRESS (If rural, give location) 747 Ray Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION Metropolitan Spiritual Church			

3. NAME OF DECEASED (Type or Print) Irene Moody			4. DATE OF DEATH (Month) (Day) (Year) 2 22 1953			
a. (First)	b. (Middle)	c. (Last)	Month	Day	Year	

5. SEX Female	6. COLOR OR RACE N. Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Unknown 1898	9. AGE (In years last birthday) 56 Yrs	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Kansas	12. CITIZEN OF WHAT COUNTRY? U. S. A
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE George W. Moody
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME George W. Moody	ADDRESS 747 Ray St Kansas City, Kansas
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Atherosclerosis	ANTECEDENT CAUSES Heart Disease		
* This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	Morbidity 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.			4200

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION History from Physicians	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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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 **11: A m.**, from the causes and on the date stated above.

23a. SIGNATURE Mrs. J. W. Jones	23b. ADDRESS 1612 E 12th	23c. DATE SIGNED 2/23/53
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 3-2-1953	24c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City Kansas
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DATE REC'D BY LOCAL REG. 3-2-53	REGISTRAR'S SIGNATURE Seraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE Mrs. J. W. Jones	ADDRESS 440 State Ave
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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.

Student
Student Embalmer

Signed *James P. Watkins*

Licensed Embalmer No. 4500

P. O. Address 18th & Benton

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.