

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4132

State File No. _____

Registrar's No. 178

BIRTH DATE JULY 28, 1884 REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007

1. PLACE OF DEATH a. COUNTY <u>Butler</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Butler</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Poplar Bluff,</u>		c. CITY OR TOWN <u>Harville,</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Poplar Bluff, Hospital</u>			
e. STREET ADDRESS (If rural, give location) <u>Route 1.</u> 0120 /			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Roy</u>	b. (Middle) <u>Warren</u>	c. (Last) <u>Moss</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>March 2, 1954</u>
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5. SEX <input type="radio"/> Male <input type="radio"/> Female	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 28, 1884</u>	9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u>3</u> Min. <u>00</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>Hillsboro, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Thomas Moss</u>	13b. MOTHER'S MAIDEN NAME <u>Caroline Reichmon</u>	14. NAME OF HUSBAND OR WIFE <u>Dora M. 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>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Ruth Stewart, Poplar Bluff, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Infarct</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Unknown</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>1st sound murmur in heart</u>		<u>Unknown</u>	

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) _____	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 May 1944 to 3-2, 1954, that I last saw the deceased alive on 3-2, 1954 and that death occurred at 1:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>J. W. Tronda, M.D.</u> (Degree or title)	23b. ADDRESS <u>Poplar Bluff, Mo.</u>	23c. DATE SIGNED <u>3-4-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>March 4, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Garden</u>	24d. LOCATION (City, town, or county) (State) <u>Poplar Bluff, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>3/6/54</u>	REGISTRAR'S SIGNATURE <u>R. H. Muntree</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>RUSSELL-ERMERT FUN. HOME, CORNING, ARK.</u>	ADDRESS _____
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489-0

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
MAR 10 1954
BUTLER CO. HEALTH CENTER
FILE No. _____

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 Me....., Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Leshie D. Russell*
Licensed Embalmer No. 385

P. O. Address Corning, Ar

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.