

FILED OCT 28 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32898

State File No.

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 386

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Knox</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u>		c. CITY OR TOWN <u>Leonard</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>40 das</u>		e. STREET ADDRESS (If rural, give location) <u>R.F.D.</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Laughlin Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Joe</u>	b. (Middle) <u>L.</u>	c. (Last) <u>Moyer</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 18, 1954</u>
-------------------------------------	-----------------------	-----------------------	------------------------	--

5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 4, 1888</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours	IF UNDER 15 MIN. Min.
-----------------	---------------------------	---	--------------------------------------	---	------------------------	------------------------	-----------------------

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 <u>Farm</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Youngstown, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	---	--	--

13a. FATHER'S NAME <u>John Moyer</u>	13b. MOTHER'S MAIDEN NAME <u>Emma Klaus</u>	14. NAME OF HUSBAND OR WIFE <u>Alma Anderson Moyer</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>X</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Kenneth Moyer, Novelty, Mo.</u>	ADDRESS
--	----------------------------------	--	---------

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		INTERVAL BETWEEN ONSET AND DEATH <u>5-6 weeks</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Intestinal Obstruction</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cancer of head of Pancreas</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>157X</u>	

19a. DATE OF OPERATION <u>7-2 & 9-17-54</u>	19b. MAJOR FINDINGS OF OPERATION <u>Cholecystojejunostomy 7-2-54 Palliative anterior gastroenterostomy 9-17-54</u>	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)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 8-30-54, 1954, to 10-18-54, 1954, that I last saw the deceased alive on 10-18-54, 1954, and that death occurred at 1:15P., from the causes and on the date stated above.

23. SIGNATURE (Degree or title) <u>Walter Lambert D.O.</u>	23b. ADDRESS <u>Kirksville, Mo.</u>	23c. DATE SIGNED <u>10-19-54</u>
--	-------------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10/20/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Highland Park</u>	24d. LOCATION (City, town, or county) (State) <u>Kirksville, Mo.</u>
---	---------------------------	---	--

DATE REC'D BY LOCAL REG. <u>10-22-54</u>	REGISTRAR'S SIGNATURE <u>Walter Lambert</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Lambert</u>	ADDRESS <u>Kirksville, Mo.</u>
--	---	--	--------------------------------

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

OCT 28 19

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.....
Signature of Student Embalmer

Signed *Kenneth E. Hayes*.....

Licensed Embalmer No. *489*.....

P. O. Address *Wickliffe, Ohio*.....

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.