

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26354
3564

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital # 1		e. STREET ADDRESS 2621 Guilnotte	

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) A. c. (Last) Moore			4. DATE OF DEATH (Month) (Day) (Year) Aug. 11 55		
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5. SEX male	6. COLOR OR RACE white	7. MARRIED (NEVER MARRIED) WIDOWED, DIVORCED (Specify) D	8. DATE OF BIRTH 1-2 1898	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILL WORKER	10b. KIND OF BUSINESS OR INDUSTRY WHEAT	11. BIRTHPLACE (City and State or Foreign Country) NEAR SCOTTSBOROUGH ALA	12. CITIZEN OF WHAT COUNTRY? U. S.
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13a. FATHER'S NAME SAMUEL TIMOTHY MOORE	13b. MOTHER'S MAIDEN NAME SARAH ELLEN BURGESS	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) YES W.W.I	16. SOCIAL SECURITY NO. 487-16-7224	17. INFORMANT'S SIGNATURE OR NAME MRS ALMA A. DEAN ADDRESS 205 N. Echo Holdenville, Ok
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severe coronary arteriosclerosis,		INTERVAL BETWEEN ONSET AND DEATH 2607
	ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		
	DUE TO (b) old Myocardial infarction, and DUE TO (c) diabetes mellitis (clinical).		
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Minute)	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 Aug. 11 1955 to Aug. 11, 1955, that I last saw the deceased alive on Aug. 11, 1955 and that death occurred at 9:15 a., from the causes and on the date stated above.

23a. SIGNATURE B. I. Burns (Degree or title) D. Burns, M.D.	23b. ADDRESS 24th & Cherry Sts.	23c. DATE SIGNED 8/12/55
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24a. BURIAL CREMATION (REMOVAL) (Specify)	24b. DATE 8-15-55	24c. NAME OF CEMETERY OR CREMATORY FT LEAVENWORTH NATIONAL CEM.	24d. LOCATION (City, town, or county) (State) FT LEAV' KANS
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DATE REC'D BY LOCAL REG. 8-13-55	REGISTRAR'S SIGNATURE Neve Marshall	25. FUNERAL DIRECTOR'S SIGNATURE SEBETO'S ADDRESS K.C. Mo
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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.....
Signature of Student Embalmer

Signed..... *Forrest D. Caldwell*

Licensed Embalmer No. *4714*

P. O. Address *K. E. W.*

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.