

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **16502**
2115

FILED MAY 31 1956

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 Mo b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL, and give township) Kansas City	c. LENGTH OF STAY (In this place) 1 wk.	c. CITY OR TOWN Independence	d. (If residence within limits of city or incorporated town?) Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Northeast Hospital		e. STREET ADDRESS (If rural, give location) 1122 West Waldo. 1005	

3. NAME OF DECEASED (Type or Print)	a. (First) Wilda	b. (Middle) Frances	c. (Last) Moore	4. DATE OF DEATH (Month) (Day) (Year) May 13 1956
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH 1881	9. AGE (In years last birthday) 75 yr	IF UNDER 21 YEARS Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Marlington West Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Moore	13b. MOTHER'S MAIDEN NAME Martha Sharp.	14. NAME OF HUSBAND OR WIFE none
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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 Amy Moore	ADDRESS 1122 West Waldo mo
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 42 hr
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute exacerbation, recurrent myocardial decompensation	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. myocardial decompensation	
	DUE TO (c)		4 weeks
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		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)	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 **5-6**, 19**56**, to **5-13**, 19**56**, that I last saw the deceased alive on **5-13**, 19**56**, and that death occurred at **10:40 Am.**, from the causes and on the date stated above.

23a. SIGNATURE M. L. Whelton, Sr.	23b. ADDRESS Kansas City, Mo.	23c. DATE SIGNED
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24a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24b. DATE MAY 15, 1956	24c. NAME OF CEMETERY OR CREMATORY Odesa	24d. LOCATION (City, town, or county) (State) Odesa Mo.
DATE REC'D BY LOCAL REG. 5-15-56	REGISTRAR'S SIGNATURE neva minshall	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. W. Stahl 815 West Maple Ave. Indep. Mo.	

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.....
Rollie Kessel

Licensed Embalmer No. 46

P. O. Address A.C.V.

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.