

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **33530**

|                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |  |                                                                                                                                      |  |
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| BIRTH NO.                                                                                                                                                                                                                                |  | REG. DIST. NO. <b>99</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |  | PRIMARY REG. DIST. NO. <b>4169</b>                                                                                                    |  | Registrar's No. <b>37</b>                                                                                                            |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>DEKALB</b>                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death)<br>a. STATE <b>Missouri</b> b. COUNTY <b>DEKALB</b> |  |                                                                                                                                      |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <b>OSBORN</b>                                                                                                                                            |  | c. LENGTH OF STAY (in this place)<br><b>17 yr.</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | c. CITY OR TOWN <b>OSBORN</b>                                                                                                         |  | d. Is residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>OSBORN Missouri</b>                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | e. STREET ADDRESS (If rural, give location)<br><b>OSBORN MO. 030</b>                                                                  |  |                                                                                                                                      |  |
| 3. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                   |  | a. (First) <b>Everett</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |  | b. (Middle) <b>R</b>                                                                                                                  |  | c. (Last) <b>Moreland</b>                                                                                                            |  |
| 4. DATE OF DEATH                                                                                                                                                                                                                         |  | (Month) <b>OCT</b> (Day) <b>16</b> (Year) <b>56</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 5. SEX <b>M</b>                                                                                                                       |  | 6. COLOR OR RACE <b>W</b>                                                                                                            |  |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>                                                                                                                                                                 |  | 8. DATE OF BIRTH <b>July 19 1898</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  | 9. AGE (in years last birthday) <b>58</b>                                                                                             |  | 10. IF UNDER 1 YEAR: Hours <b>0</b> Min. <b>0</b>                                                                                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Supervisor</b>                                                                                                                         |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Pipe Line</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>West Virginia (Schultz)</b>                                                  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                           |  |
| 13a. FATHER'S NAME<br><b>ELIZA N Moreland</b>                                                                                                                                                                                            |  | 13b. MOTHER'S MAIDEN NAME<br><b>Ida Belle Baker</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 14. NAME OF HUSBAND OR WIFE<br><b>Florence Moreland</b>                                                                               |  |                                                                                                                                      |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>P</b>                                                                                                                     |  | 16. SOCIAL SECURITY NO.<br><b>330-10-1712</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 17. INFORMANT'S SIGNATURE OR NAME<br><b>Florence Moreland Osborn Mo.</b>                                                              |  |                                                                                                                                      |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Thrombosis</b><br><b>myocardial infarction</b><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |                                                                                                                                       |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>15 minutes</b>                                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                   |  | 19b. MAJOR FINDINGS OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 420.1                                                                                                                                 |  | 20. AUTOPSY?<br>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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>5:00 P.M.</b> , from the causes and on the date stated above. |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |  |                                                                                                                                      |  |
| 23a. SIGNATURE<br><b>Ed Hetherton</b>                                                                                                                                                                                                    |  | (Degree or title)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. ADDRESS<br><b>Cameron Mo</b>                                                                                                     |  | 23c. DATE SIGNED<br><b>10-18-56</b>                                                                                                  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                               |  | 24b. DATE<br><b>Oct-19-56</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Osborn</b>                                                                                   |  | 24d. LOCATION (City, town, or county) (State)<br><b>Osborn Mo</b>                                                                    |  |
| DATE REC'D BY LOCAL REG.<br><b>10-23-56</b>                                                                                                                                                                                              |  | REGISTRAR'S SIGNATURE<br><b>Roscoe Davidson</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>Poland Funeral Home</b>                                                                        |  | ADDRESS<br><b>Cameron Mo.</b>                                                                                                        |  |

(Licensed Embalmer's Statement on Reverse Side)

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..... Robert F Poland

Licensed Embalmer No. 4772

P. O. Address 222 West 34th St  
Cameron, N.Y.

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.