

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

818

STATE FILE NUMBER

FILED JAN 28 1957

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dunklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Tennett</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Malden</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Dunklin County Hpl</u> Length of stay in 1b <u>One day</u>		d. STREET ADDRESS (If outside, give location) <u>409 E Howard</u> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Carroll Robert Moylan</u> First Middle Last			4. DATE OF DEATH <u>Jan 4 - 1957</u> Month Day Year		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1892-9-21</u>	9. AGE (In years last birthday) <u>64-3-13</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Retired)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Buttsville, MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Moylan</u>	14. MOTHER'S MAIDEN NAME <u>Mollie Adkinson</u>		

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 <u>Mrs. Moylan, Malden Mo - 409 E Howard</u> Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>1/4/57</u> COUNTY STATE
21. I attended the deceased from <u>1/4/57</u> to <u>1/4/57</u> and last saw him alive on <u>1-4-57</u> Death occurred at <u>12:25 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>George J. Summers</u> (Degree or title)	22b. ADDRESS <u>Kennett, Mo.</u>	22c. DATE SIGNED <u>1-12-57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan 6 - 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Malden Park Memorial</u>	23d. LOCATION (City, town, or county) (State) <u>N of Malden Mo</u>
24. FUNERAL DIRECTOR <u>T. C. Knight</u> ADDRESS <u>Malden Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Jan 14 - 1957</u>	26. REGISTRAR'S SIGNATURE <u>Earl Thurman</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All

MEDICAL CERTIFICATION

RECEIVED DUNKLIN COUNTY  
DEPARTMENT ..... 1-  
COUNTY FILE NUMBER .....

MAR 28 1957

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 *Thomas C. Knight*

Licensed Embalmer No. *21*

P. O. Address *Walden*

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..