FILED APR 10 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 8806

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1365

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen'l Hosp. #1 — Length of stay in this place 35 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 347 N. Hardesty — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Arthur Middle: L. Last: Moore

4. DATE OF DEATH Month: 3 Day: 22 Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12-20-1868

9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter & Paperhanger

10b. KIND OF BUSINESS OR INDUSTRY: self

11. BIRTHPLACE (City and state or country): Liberty, Mo

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James M. Moore

14. MOTHER'S MAIDEN NAME: Rachael Howard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Weber Moore — Address: 5223 Woodland K.C. Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Arteriosclerosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Pulmonary Fibrosis and Emphysema
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 4500

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from March 5, 1957, to March 22, 1957 and last saw him alive on March 22, 1957
Death occurred at 8:55 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE B. I. Burns (Degree or title) M.D.

22b. ADDRESS 24th & Cherry

22c. DATE SIGNED 3-22-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 3/25/1957

23c. NAME OF CEMETERY OR CREMATORY New Hope Cemetery

23d. LOCATION (City, town, or county) (State) Liberty, Mo

24. FUNERAL DIRECTOR C. H. Blackman & Son — ADDRESS K.C. Mo

25. DATE RECD. BY LOCAL REG. 3-23-57

26. REGISTRAR'S SIGNATURE Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms in Item 18. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed Bert B. Bennet

Licensed Embalmer No. 46

P. O. Address D. C.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.

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2