

FILED SEP 13 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28692
STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 217

300
-57

1. PLACE OF DEATH a. COUNTY Livingston		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Livingston	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chillicothe		c. CITY OR TOWN Chillicothe	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 313 Calhoun		d. STREET ADDRESS (If outside, give location) 313 Calhoun	
3. NAME OF DECEASED (Type or print) First Edwin Middle H. Last Moss		4. DATE OF DEATH Month Sept. Day 5, Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY Own office	11. BIRTHPLACE (City and state or country) Chillicothe Mo.
13a. FATHER'S NAME John T. Moss		13b. MOTHER'S MAIDEN NAME Hester J. Crockett	14. NAME OF HUSBAND OR WIFE xx
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. xx	17. INFORMANT W. Reed Moss, Chillicothe, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) arterio sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 3 weeks 15 yrs
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	COUNTY _____ STATE _____
21. I attended the deceased from Aug 9 - 8 to 57 Sept - 5 - 57 and last saw him alive on sept - 5 - 57 Death occurred at 9:25 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) W.C. Carpenter M.D.		22b. ADDRESS Chillicothe Mo.	22c. DATE SIGNED 9/7/57
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 9/7/57	23c. NAME OF CEMETERY OR CREMATORY Edgewood cemetery	23d. LOCATION (City, town, or county). (State) Chillicothe, Mo.
24. FUNERAL DIRECTOR Donald Gordon, Chillicothe, Mo.		25. DATE RECD. BY LOCAL REG. 9/7/57	26. REGISTRAR'S SIGNATURE Francis B. Neill

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Ronald Jordan*

Licensed Embalmer No. *4191*
P. O. Address *Chilli coile*

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.