

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

739

STATE FILE NUMBER

FILED FEB 10 1958

Registration District No. 98 Primary Registration District No. 4161 Registrar's No. 29

1. PLACE OF DEATH a. COUNTY <u>Daviess</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Daviess</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jameson</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Jameson</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>---</u>	Length of stay in lb <u>19 Yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>---</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Franklin</u> Last <u>Moulin</u>			4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8, 1886</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Labor</u>	11. BIRTHPLACE (City and state or country) <u>Daviess Co. Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>Anderson Moulin</u>	13b. MOTHER'S MAIDEN NAME <u>Alice Smith</u>	14. NAME OF HUSBAND OR WIFE <u>Eunice Moulin (Dec'd)</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>493-18-6094</u>	17. INFORMANT Address <u>Mrs. Dorothy Eads, Jameson, Mo.</u>

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>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertension</u>	
	DUE TO (c) <u>arterial Sclerosis, Chronic Nephritis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331X</u>		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 <u>8:40A</u> Month <u>June</u> Day <u>1958</u> Year <u>1958</u> a.m. p.m.	

20d. INJURY OCCURRED WHILE AT <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>Jameson</u>	COUNTY <u>Daviess</u>	STATE <u>Missouri</u>
21. I attended the deceased from <u>June 1950</u> to <u>Jan 31</u> and last saw her/him alive on <u>Jan 31/58</u> Death occurred at <u>8:40A</u> on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>H. W. Barry D.D.</u> (Degree or title)	22b. ADDRESS <u>Gallatin, Mo</u>	22c. DATE SIGNED <u>2-3-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-2-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Daviess County, Missouri</u>
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24. FUNERAL DIRECTOR <u>Hope Funeral Home, Gallatin, Mo.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>5th Feb. 1958</u>	26. REGISTRAR'S SIGNATURE <u>Vergina M. Engelbert</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related

FEB 19 1958

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 *L. O. Johnson*

Licensed Embalmer No. *3307*
P. O. Address *Ballantyne*

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.