

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1355

STATE FILE NUMBER

228

FILED FEB 3 1958

Registration District No. 149 Primary Registration District No. 1001 Registrar's No. 228

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-57 4

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>KANSAS CITY</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>PEARLS NURSING HOME</u>		Length of stay in 1b <u>52 YEARS</u>	d. STREET ADDRESS (If outside, give location) <u>2800 EAST 10TH STREET</u> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>M.</u> Last <u>MOORE</u>			4. DATE OF DEATH Month <u>JAN.</u> Day <u>13</u> Year <u>1958</u>		
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 24 1875</u>	9. AGE (In years last birthday) <u>82</u>	10. UNDER 1 YEAR Months <u>8</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>	11. UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>NEAR MAYFIELD, KENTUCKY</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>WESTON H. MOORE</u>	13b. MOTHER'S MAIDEN NAME <u>FLORENCE SARGEANT</u>	14. NAME OF HUSBAND OR WIFE <u>-</u>
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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>NONE</u>	17. INFORMANT <u>MRS. JAMES KOCH</u> Address <u>7011 BIRCH PARADISE VILLAGE KANSAS</u>
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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>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>9 hrs</u> <u>450</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) <u>arteriosclerosis</u>		
DUE TO (c) <u>-</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.) <u>-</u>
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20c. TIME OF INJURY Hour <u>-</u> Month, Day, Year a.m. <u>-</u> p.m. <u>-</u>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>	20f. CITY, TOWN, OR LOCATION <u>-</u>	COUNTY <u>-</u>	STATE <u>-</u>
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21. I attended the deceased from <u>12-1-57</u> to <u>1-13-58</u> and last saw her alive on <u>1-13-58</u> Death occurred at <u>-</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Frank Paul Laurence</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>428 S. White Ave</u>	22c. DATE SIGNED <u>1-13-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JAN-15-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. WASHINGTON CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>
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24. FUNERAL DIRECTOR <u>DR. NEWCOMER'S SONS</u> ADDRESS <u>1331 BRUSH CREEK KANSAS CITY, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>1-15-58</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

Frank Paul Laurence MD
MEDICAL CERTIFICATION
ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.
Doctor, coroner, etc. must use only standard nomenclature in their reports. No symptoms or signs to be given.



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 Basil Honey

Licensed Embalmer No. 4724
P. O. Address K.C., Mo.

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.