

Health, Welfare, Public Service

FILED MAR 3 - 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005729

STATE FILE NUMBER

627

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

300
-57 4

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Westport Nursing		Length of stay in lb 68 Yrs.	d. STREET ADDRESS (If outside, give location) 4012 Harrison Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JENNIE Middle P. Last MOAD			4. DATE OF DEATH Month Feb. Day 4, Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-1882
9. AGE (In years last birthday) 75		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Anville, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME -- Kunkemann	
13b. MOTHER'S MAIDEN NAME Elizabeth Bickel		14. NAME OF HUSBAND OR WIFE Otto A. Moad	
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. None	17. INFORMANT Otto A. Moad Address K. C. 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) Arteriosclerotic Heart Disease - Heart Failure Interval between ONSET AND DEATH 6 Yrs. DUE TO (b) Cerebral arteriosclerosis DUE TO (c) 4200 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.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>			
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 Sept 57. to Feb 4 '58 and last saw her alive on Feb 3 '58 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE A. W. Robinson (Degree or title) M.D.		22b. ADDRESS 4635 Argonnette	22c. DATE SIGNED 2-4-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-6-58	23c. NAME OF CEMETERY OR CREMATORY Forest Hill	23d. LOCATION (City, town, or county) Kansas City, Mo.
24. FUNERAL DIRECTOR Freeman Mortuary ADDRESS K. C. Mo.		25. DATE RECD. BY LOCAL REG. 2.6.58	26. REGISTRAR'S SIGNATURE Neva Minshall

MEDICAL CERTIFICATION

A. W. Robinson USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

H. C. Allen Robinson

4635 Spandorff



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 *Walter H. Carwin*

Licensed Embalmer No. *4352*
P. O. Address *H. 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.