

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-025687

STATE FILE NUMBER

3555

FILED AUG 15 1958

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

S. 300  
y. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

MEDICAL CERTIFICATION  
Clarence S. Coffey USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3008 Euclid Ave.</b>			Length of stay in lb <b>54 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>3008 Euclid Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle Last <b>Moore</b>				4. DATE OF DEATH Month <b>July</b> Day <b>18</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 20, 1873</b>		9. AGE (In years last birthday) <b>85</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundry</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>	11. BIRTHPLACE (City and state or country) <b>Foristell, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13a. FATHER'S NAME <b>TOM MOORE</b>			13b. MOTHER'S MAIDEN NAME <b>Martha (Unknown)</b>		14. NAME OF HUSBAND OR WIFE <b>OLLIE Olivia Moore</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>487-03-5441</b>	17. INFORMANT <b>OLLIE Mrs. Olivia Moore, 3008 Euclid Avenue</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular infarction</b>						INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Vascular Hypertension</b>						<b>Unknown</b>	
DUE TO (c) <b>hypertensive cardio vascular renal disease Chronic Renal and Vascular disease</b>						<b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>442+</b>						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 _____ a.m. _____ p.m. Month, Day, Year _____							
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		COUNTY STATE	
21. Attended the deceased from <b>7/14/58</b> to <b>7/18/58</b> and last saw him alive on <b>7/17/58</b> Death occurred at <b>8:15 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Clarence S. Coffey</i>				22b. ADDRESS <b>1224 East 12th</b>		22c. DATE SIGNED <b>7/22/58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/23/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>		
24. FUNERAL DIRECTOR <b>Badeau, Appleton &amp; Jones, K.C., Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>7-22-58</b>	26. REGISTRAR'S SIGNATURE <i>Olivia Minshall</i>			



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 Carol - Gladys Bode

Licensed Embalmer No. 4944  
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.