

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038054
STATE FILE NUMBER

FILED OCT 30 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's 9964

| | | | | | |
|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Masonic Home of Missouri | | 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) OR TOWN St. Louis, Mo. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY St. Louis OR TOWN Kansas City | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Masonic Home of Mo. | | Length of stay in 1b | | d. STREET ADDRESS (If outside, give location) 4220 Olive St. | |
| Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | 3/ | | | |

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|---|---------------------------|---|--|---------------------------------------|-------------------------------------|
| 3. NAME OF DECEASED (Type or print) First Middle Last Martha (Mattie) R Moyer | | | 4. DATE OF DEATH Month Day Year 10 17 58 | | |
| 5. SEX F. | 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 10-8-1872 | 9. AGE (In years last birthday) 86 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (City and state or country) Richland, Penna. / | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Peter Gockley | | | 14. MOTHER'S MAIDEN NAME Sussanah Reinhold | | |
| 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. INSURANT Address Charles B. Gockley 4038 Miami | | |

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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) CEREBRAL HEMORRHAGE WITH RIGHT HEMIPLEGIA DUE TO (b) HYPERTENSION DUE TO (c) 331X Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH 8 DAYS 2 YEARS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PREVIOUS CEREBRAL HEMORRHAGE 1954 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 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 Month, Day, Year a. m. p. m. | | |
| 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 5-26-56, to 10-17-58 and last saw her alive on 10-17-58
Death occurred at 4:45 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) Robert A. Hall, M.D. | 22b. ADDRESS 3902 Lafayette | 22c. DATE SIGNED 10/17/58 |
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|--|---------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE Oct 19, 1958 | 23c. NAME OF CEMETERY OR CREMATORY Green Lawn | 23d. LOCATION (City, town, or county) (State) Kansas City Mo |
|--|---------------------------|--|---|

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| 24. FUNERAL DIRECTOR E. J. Schnur 3125 Lafayette | 25. DATE RECD. BY LOCAL REG. OCT 20 1958 | 26. REGISTRAR'S SIGNATURE J. C. Smith MD m. B. |
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(Licensed Embalmer's Statement on Reverse Side)

300
1-56

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. Coroner cannot certify to a death due to natural causes.

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 *Joseph Vollmer*.....
Licensed Embalmer No. *4014*

P. O. Address *4014*
3125 Lafayette

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.