

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-039635

STATE FILE NUMBER

FILED DEC 1 1958

Registration District No. 128 Primary Registration District No. Registrar's No. 117

1. PLACE OF DEATH a. COUNTY Green County			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Green		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Galloway Mo		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Galloway Mo		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Galloway Mo		Length of stay in lb 4 Months	d. STREET ADDRESS (If outside, give location) Galloway Mo		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Emma Middle Gass Last Gass			4. DATE OF DEATH Month Nov Day 19 Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct, 20, 1858	9. AGE (In years last birthday) 100	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Dallas Co, Mo	
13. FATHER'S NAME James Rice			14. MOTHER'S MAIDEN NAME Fannie Ann Williams		
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. x	17. INFORMANT Address Everett Gass, Sparta 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) Cardiac Insufficiency					INTERVAL BETWEEN ONSET AND DEATH 18 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4200					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 p. m. Month, Day, Year					
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 10-4-58 to 11-19-58 and last saw her alive on 11-19-58 Death occurred at 9:50 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE F. Thomas Moseley, M.D.			22b. ADDRESS 1636 So. Glenstone Springfield, Mo.		22c. DATE SIGNED 11-25-58
23a. BURIAL, CREMATION, REBURY (Specify) Burial		23b. DATE 11-22-58	23c. NAME OF CEMETERY OR CREMATORY Sparta Cemetry		23d. LOCATION (City, town, or county) (State) Christian Mo
24. FUNERAL DIRECTOR T. B. Chaffin		ADDRESS Ozark Mo.		25. DATE RECD. BY LOCAL REG. 11-28-58	26. REGISTRAR'S SIGNATURE Effie G. Melton

(Licensed Embalmer's Statement on Reverse Side)

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All symptoms must be listed. All service

-USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300
1-56

Health,
Welfare
Public
Service

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... *T. B. Cheffin*

Licensed Embalmer No. *21*

P. O. Address... *Ozan*

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.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-039635

STATE FILE NUMBER

REC DEC 1 1958

Registration District No. 128

Primary Registration District No.

Registrar's No. 1117

1. PLACE OF DEATH a. COUNTY Green County		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Mo b. COUNTY Green	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR Galloway Mo Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Galloway Mo c 390	Inside Limits Yes: No: <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Galloway Mo		Length of stay in lb 4 Months	d. STREET ADDRESS (If outside, give location) Galloway Mo Reside on Farm Yes: No: <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) Emma Narcissis Gass			4. DATE OF DEATH Nov 19/1958		
5. SEX Female	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 Oct. 20, 1858	9. AGE (In years last birthday) 100	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Dallas Co, Mo	12. CITIZEN OF WHAT COUNTRY? U S A
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13. FATHER'S NAME John James Rice	14. MOTHER'S MAIDEN NAME Fannie Ann Williams
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give name or dates of service) No	16. SOCIAL SECURITY NO. X	17. EMPLOYMENT ADDRESS Everett Gass, Sparta Mo
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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) Cardiac Insufficiency		INTERVAL BETWEEN ONSET AND DEATH 18 hrs.
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.	DUE TO (b) Arteriosclerotic Heart Disease	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4200		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: Min: Sec: Day: Year	

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
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21. I attended the deceased from **10-4-58** to **11-19-58** and last saw her alive on **11-19-58**
Death occurred at **9:50 AM** on the date stated at _____ and to the best of my knowledge, from the causes stated.

21a. SIGNATURE F. Thomas Mosaley	21b. ADDRESS 1636 So. Glenstone Springfield, Mo	21c. DATE SIGNED 11-25-58
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22a. BURIAL CREMATION Burial	22b. DATE 11-22-58	22c. NAME OF CEMETERY OR CREMATOR Sparta Cemetery	22d. LOCATION (City, town, or county) Christian Mo
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24. FUNERAL DIRECTOR T. B. Chaffin	ADDRESS Ozark Mo	25. DATE RECD. BY LOCAL REG. 11-28-58	26. REGISTRAR'S SIGNATURE Effie G. Melton
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(Licensed Embalmer's Statement on Reverse Side)

Item # 3.13 amended by affidavit of deceased granddaughter 3-6-95

USE ONLY BLACK INK OR RED INK OR RED INK TYPEWRITE IF POSSIBLE

diseases in Part I must be equally related. Cancer cannot certify to a death due to natural causes. All other diseases must be certified to a death due to natural causes.

