

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043325

STATE FILE NUMBER

Registration District No. 012 Primary Registration District No. 1000 Registrar's No. 1330

FILED DEC 22 1958

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2419 St. Joseph Ave.		Length of stay in lb life	d. STREET ADDRESS (If outside, give location) 2419 St. Joseph Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ANNA I. MOSER			4. DATE OF DEATH Month Day Year December 11, 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 Dec. 20, 1892		9. AGE (In years last birthday) 65
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher		10b. KIND OF BUSINESS OR INDUSTRY public school		11. BIRTHPLACE (City and state or country) St. Joseph, Mo.	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Hans J. Olson		13b. MOTHER'S MAIDEN NAME Karen Erickson	
14. NAME OF HUSBAND OR WIFE Charles Moser		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. 497-32-2901	
17. INFORMANT Address Edwin Olson, 2419 St. Joseph Ave., St. Joseph, 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) General Carcinomatosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Metastasis of Pancreatic Carcinoma DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 159X			
19. INTERVAL BETWEEN ONSET AND DEATH 1 year		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2			
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 <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 Death occurred at Jan 1957 to Dec. 11, 1958 and last saw her/him alive on Dec. 8, 1958 10:20p. m on the date stated above; and to the best of my knowledge, from the causes stated.		22. SIGNATURE (Degree or title) Genevieve M. D.		22b. ADDRESS 1014 1/2 St. Joseph, Mo.	
22c. DATE SIGNED 12/12/58		23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 12/15/1958	
23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		23d. LOCATION (City, town, or county) St. Joseph		23e. STATE Missouri	
24. FUNERAL DIRECTOR Hester Bowman		ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Dec. 12, 1958	
26. REGISTRAR'S SIGNATURE Mr. Clark Standell					

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

Dr. S. E. Meade

MEDICAL CERTIFICATION

BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *William Spalding*

Licensed Embalmer No. *4535*

P. O. Address *St Joseph*

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.