

FILED JAN 23 1959

XC-352659

REG.#16681

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000408

STATE FILE NUMBER

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 28

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>WAYNE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>PIEDMONT</b> <u>1110</u> 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>VETERANS ADM. HOSPITAL 198 DAYS</b>		Length of stay in 1b <b>198 DAYS</b>	d. STREET ADDRESS (If outside, give location) <b>NONE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MANUEL</b> Middle <b>MUNOZ</b> Last <b>MOON</b>			4. DATE OF DEATH Month <b>JANUARY</b> Day <b>9</b> Year <b>1959</b>
5. SEX <b>MALE</b> <u>0</u>	6. COLOR OR RACE <b>WHITE</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>4/17/87</b>
9. AGE (In years last birthday) <b>71</b>		IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>	IF UNDER 24 HRS. Hours <u>    </u> Min. <u>    </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAXI DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TRANSPORTATION</b>	11. BIRTHPLACE (City and state or country) <b>SAN CARLOS, MEXICO</b> <u>3</u>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>GONZALE MOON</b>	
13b. MOTHER'S MAIDEN NAME <b>ANTONIO LUNA</b>		14. NAME OF HUSBAND OR WIFE <b>ALMA MOON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>YES</b> <u>WWI</u>		16. SOCIAL SECURITY NO. <b>488266035</b>	17. INFORMANT Address <b>VA HOSPITAL RECORDS, POPLAR BLUFF, MO.</b>
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>CARCINOMA OF STOMACH WITH GENERALIZED METASTASES.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>13 Months.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>PERNICIOUS ANEMIA.</b>			<b>At least 10 Years.</b>
DUE TO (c) <u>    </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>1. TERMINAL CACHEXIA. 2. MALNUTRITION.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>NO 2</u>
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 <u>    </u> Month, Day, Year a.m. <u>    </u> p.m. <u>    </u>			
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.)	
<b>VA</b>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>June 25, 1958</b> to <b>Jan. 9, 1959</b> Death occurred at <b>3:28 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Robert S. Cohen, M.D., Chief, Med. Svc.</b>		22b. ADDRESS <b>VA HOSPITAL, POPLAR BLUFF, MO.</b>	22c. DATE SIGNED <b>1/12/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-11-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Masonic</b>	23d. LOCATION (City, town, or county) (State) <b>Piedmont, Mo.</b>
24. FUNERAL DIRECTOR <b>William Cohen Piedmont</b>		25. DATE RECD. BY LOCAL REG. <b>1/17/59</b>	26. REGISTRAR'S SIGNATURE <b>R. Mueller</b>

(Licenses of Informant's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

ALL diseases in Part I must be causally related.

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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 Ceder Fonseca / Home, Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed William Boehr

Licensed Embalmer No. 3723

P. O. Address Richmond, VA

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.