

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001614

STATE FILE NUMBER

FILED JAN 27 1959

Registration District No. 146

Primary Registration District No. 3026

Registrar's No. 41

300  
-57

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| 1. PLACE OF DEATH<br>a. COUNTY Jackson   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Mo. b. COUNTY Jackson |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN Independence            |  | c. CITY OR TOWN Independence  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION 420 W. Farmer |  | d. STREET ADDRESS (If outside, give location)<br>420 W. Farmer  |  |
| Length of stay in lb<br>60 yrs.  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                   |  |

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|--|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First MARY Middle ADELIA Last MOORE |  |  | 4. DATE OF DEATH<br>Month January Day 20, Year 1959 |  |  |
|--|--|--|---|--|--|

|                  |                           |   |                                   |                                       |   |                  |
|------------------|---------------------------|---|-----------------------------------|---------------------------------------|---|------------------|
| 5. SEX<br>Female | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Mar. 20, 1865 | 9. AGE (In years last birthday)<br>93 | 10. FUNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS. |
|------------------|---------------------------|---|-----------------------------------|---------------------------------------|---|------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>At Home | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country)<br>Warrensburg, Mo. | 12. CITIZEN OF WHAT COUNTRY?<br>USA |
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| 13a. FATHER'S NAME<br>Alfred Bell Harrison | 13b. MOTHER'S MAIDEN NAME<br>Elizabeth Fransisco | 14. NAME OF HUSBAND OR WIFE<br>W. E. Moore, dec. |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No | 16. SOCIAL SECURITY NO.<br>None | 17. INFORMANT<br>Mr. J. A. Hininger, Indep., Mo. | Address |
|---|---------------------------------|--|---------|

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Aneurysm of abdominal aorta</u><br><u>Severely &amp; arteriosclerosis</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (b) _____<br>DUE TO (c) _____ |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Unknown</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>451X</u>  |  | 19. WAS AUTOPSY PERFORMED?<br>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.) |
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| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m. |
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|---|--|--|
| 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<br>COUNTY STATE |
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| 21. I attended the deceased from <u>Nov 1958</u> to <u>Jan 59</u> and last saw her <sup>her</sup> alive on <u>13 Jan 59</u><br>Death occurred at <u>approx 3:30 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |
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|   |                                     |                                    |
|---|-------------------------------------|------------------------------------|
| 22a. SIGNATURE<br><u>J. A. Hininger</u> (Degree or title) | 22b. ADDRESS<br><u>Independence</u> | 22c. DATE SIGNED<br><u>1-21-59</u> |
|---|-------------------------------------|------------------------------------|

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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u> | 23b. DATE<br><u>Jan. 22, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Woodlawn</u> | 23d. LOCATION (City, town, or county) (State)<br><u>Independence, Missouri</u> |
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| 24. FUNERAL DIRECTOR<br><u>OTT &amp; MITCHELL, Indep., Mo.</u> | 25. DATE RECD. BY LOCAL REG.<br><u>1-22-59</u> | 26. REGISTRAR'S SIGNATURE<br><u>James K. King</u> |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *Henry J. Mitchell*  
Licensed Embalmer No. *3925*  
P. O. Address *Indep, 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.