

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008061

STATE FILE NUMBER

FILED FEB 16 1959

Registration District No. 324 Primary Registration District No. 6082 Registrar's No. 23

300
1-57

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Saline	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Arrow Rock Township		c. CITY OR TOWN Arrow Rock Township	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Marshall		d. STREET ADDRESS (If outside, give location) Arrow Rock Star Rt.	
3. NAME OF DECEASED (Type or print) First Forrest Middle Lee Last Moseley		4. DATE OF DEATH Month Feb. Day 10 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11b. KIND OF BUSINESS OR INDUSTRY Farm	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME John Moseley		13b. MOTHER'S MAIDEN NAME Henrietta Painter	14. NAME OF HUSBAND OR WIFE Virginia K. Moseley
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. 490-42-9086A	17. INFORMANT Address Rt Arrow Rock Star
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 DUE TO (b) Hypertensive Cardiovascular Dis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 90 min 102 min
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 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 6:30 Feb 10 1959 and last saw her/him alive on 7-10-1959		m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE Marvin E. Locke, M.D.		22b. ADDRESS Marshall, Mo	22c. DATE SIGNED 2/10/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-12-1959	23c. NAME OF CEMETERY OR CREMATORY Arrow Rock Cemetery	23d. LOCATION (City, town, or county) (State) Arrow Rock, Missouri
24. FUNERAL DIRECTOR Campbell-Lewis Marshall, Mo.		25. DATE RECD. BY LOCAL REG. 2-11-59	26. REGISTRAR'S SIGNATURE Cecil J. Read

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms which are related. 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 *James H. Lewis*.....
Licensed Embalmer No. *4709*.....
P. O. Address *Marshall, 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.