

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013456

FILED MAY 13 1959

Registration District No. _____

149

Primary Registration District No. _____

1002

STATE FILE NUMBER _____
1943

Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Johnson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		c. CITY OR TOWN Mission	
c. FULL NAME OF (If NOT in hospital, give location) St. Luke Hospital		Length of stay in 1b 4 Days	
8. STREET ADDRESS 5208 Walnut		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle A. Last Moses			4. DATE OF DEATH Month April Day 16 Year 1959
5. SEX M	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 Sept 13 1878
9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman	11. BIRTHPLACE (City and state or country) Rosedale Kansas
10a. FATHER'S NAME James E Moses		10b. KIND OF BUSINESS OR INDUSTRY Government Employee	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. MOTHER'S MAIDEN NAME Elizabeth Jones		14. NAME OF HUSBAND OR WIFE Cattie E. Moses	
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. 509-10-2113	17. INFORMANT Mrs. Ray Luhnow Leewood Kans.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) General debility DUE TO (c) Recent past pyelonephritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 6000			INTERVAL BETWEEN ONSET AND DEATH
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 _____ a.m. _____ p.m. Month, Day, Year _____		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 Apr 5, 1959 , to Apr 16 1959 and last saw ^{her} him alive on Apr 16, 1959 Death occurred at 7 am on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Hugh W. McCaughey MD		22b. ADDRESS 5615 Johnson Dr - Mission Mo	
22c. DATE SIGNED Apr 17 1959		22d. LOCATION (City, town, or county) (State) Kansas City Missouri	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Apr 18 1959	
23c. NAME OF CEMETERY OR CREMATORY Farrest Hill Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City Missouri	
24. FUNERAL DIRECTOR D.W. Newcomers Sons K.P. Missouri		25. DATE RECD. BY LOCAL REG. 4-18-59	
26. REGISTRAR'S SIGNATURE New Marshall			

High W. McCaughey

MEDICAL CERTIFICATION USE ONLY 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 *Basil Abney*

Licensed Embalmer No. *1472*

P. O. Address *70 71*

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.