

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016841

STATE FILE NUMBER

FILED MAY 18 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 496

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b> 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>624 Prospect Leon Nursing Home</b>		Length of stay in lb <b>6 days</b>	d. STREET ADDRESS (If outside, give location) <b>1013 Vine Street</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Gail</b> Middle <b>Millie</b> Last <b>Moore</b>			4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1959</b>		
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5. SEX <b>Female</b>	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>Jan. 13, 1891</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Ste rling, Ne braska</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Edward Owen</b>	13b. MOTHER'S MAIDEN NAME <b>Doris Garland</b>	14. NAME OF HUSBAND OR WIFE <b>Earl P. Moore</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT <b>Earl P. Moore, St. Joseph, Missouri</b>	Address
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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>Paralysis agitans</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>350x</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.) <b>350x</b>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>St. Joseph, Mo.</b>	COUNTY <b>Buchanan</b>	STATE <b>Missouri</b>
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21. I attended the deceased from <b>5/1/59</b> to <b>5/8/59</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>5/8/59</b> Death occurred at <b>1:40 p</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>Earyle Potter, M.D.</i>	22b. ADDRESS <b>Phy. &amp; Surg. Bldg.-St. Joseph, Mo.</b>	22c. DATE SIGNED <b>5/11/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5/11/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Jamestown, Kansas</b>	23d. LOCATION (City, town, or county) (State) <b>Jamestown, Kansas</b>
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24. FUNERAL DIRECTOR <b>Heaton-Bowman Funeral Home, St. Joseph</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>May 11, 1959</b>	26. REGISTRAR'S SIGNATURE <i>Wm. Charles Stoddell</i>
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(Licensed Embalmer's Statement on Reverse Side)

Dr. Caryle Potter is the only black ribbon typewriter if possible  
MEDICAL CERTIFICATION

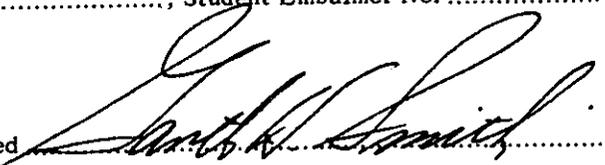
All diseases in Part I must be causally related.

Dr. Beryl Po

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 

Licensed Embalmer No. 3927  
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.