

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021576  
STATE FILE NUMBER  
2712

DECEASED JUN 17 1959 Registration District No. 149 Primary Registration District No. 1602 Registrar's No.

300  
1-57 0

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</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>General # 1</b>		Length of stay in 1b <b>15 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>2403 Sales</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Moss</b> Last <b>Moss</b>			4. DATE OF DEATH Month <b>5</b> Day <b>29</b> Year <b>59</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 3, 1921</b>	9. AGE (In years last birthday) <b>37</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>29</b>	IF UNDER 24 HRS. Hours <b>59</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waiter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>	11. BIRTHPLACE (City and state or country) <b>Fert Smith, Arkansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>John Moss Sr.</b>	13b. MOTHER'S MAIDEN NAME <b>Evelyn Craig</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> or unknown) (If yes <b>None</b> or dates of service)	16. SOCIAL SECURITY NO. <b>430-18-4145</b>	17. INFORMANT <b>Lean Moss</b> Address <b>2403 Sales</b>
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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>Hemorrhagic Shock</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Massive Hemoperitoneum</b>	
	DUE TO (c) <b>Penetrating Gunshot Wound of Abdomen</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (If not related to the terminal disease condition given in PART I (a))		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Don't Know</b>
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20c. TIME OF INJURY Hour <b>1:45</b> Month <b>5</b> Day <b>29</b> Year <b>1959</b> a.m.
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>2423 E 23</b>	20f. CITY, TOWN, OR LOCATION <b>Kansas City</b> COUNTY <b>Jackson</b> STATE <b>Mo.</b>
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>L. M. Tillman</b> <b>Deputy Coroner</b>	22b. ADDRESS <b>1618 Lydia Ave</b>	22c. DATE SIGNED <b>5/29/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6-2-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City</b>	23d. LOCATION (City, town, or county) (State) <b>Fert Smith, Arkansas</b>
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24. FUNERAL DIRECTOR <b>Lawrence A. Jones</b> ADDRESS <b>2304</b>	25. DATE RECD. BY LOCAL REG. <b>6-2-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>
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(Licensed Embalmer's Statement on Reverse Side)

L. M. Tillman USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

DEC 8 1959

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 *[Signature]*

Licensed Embalmer No. *4429*

P. O. Address *2304 [unclear]*

\*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.