

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024416

FILED VS JUL 21 1959 **53**

Registration District No. _____ Primary Registration District No. **0000** Registrar's No. **250**

STATE FILE NUMBER

NEED

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Whiteriver</u> Length of stay in 1b _____ c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Oak Ridge R ma</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Cape Gir.</u> c. CITY OR TOWN <u>Oak Ridge R. Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>5 miles west Oak Ridge</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Mae</u> Last <u>Moore</u>			4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1959</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5, 1959</u>	9. AGE (by birthday) <u>65</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home Near Oak Ridge Mo</u>		11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>William Lape</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Varnum</u>		13c. NAME OF HUSBAND OR WIFE <u>Ed Moore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT <u>Ed Moore</u>		Address <u>Oak Ridge, Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterioneuroclerosis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertensive Cardiovascular Disease.</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year _____				
20d. INJURY OCCURRED WHILE AT WORK <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 5-3-56 to 7-5-59 and last saw her alive on 7-5-59
 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>J. N. Jaeger, MD</u>	22b. ADDRESS <u>Jackson, Mo</u>	22c. DATE SIGNED <u>7-7-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 7, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cany Fork</u>	23d. LOCATION (City, town, or county) (State) <u>Oak Ridge R. Mo.</u>
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24. FUNERAL DIRECTOR <u>S. C. Cravate</u>	ADDRESS <u>Jackson, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>7-16-1959</u>	26. REGISTRAR'S SIGNATURE <u>Irene Kasten</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Raymond Stoll

Licensed Embalmer No. 2476

P. O. Address Jackson

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.