

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025308

FILED VS AUG 14 1959 149

Registration District No. 1002 Primary Registration District No. Registrar's No. 3709 STATE FILE NUMBER

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) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>31 yrs</b>		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>307 W. 13</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>307 W. 13</b>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ELSIE</b> Middle <b>MOORE</b> Last <b>MOORE</b>				4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1959</b>			
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>Dec. 10, 1900</b>	9. AGE (last birthday) <b>58</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Capri Theatre</b>		11. BIRTHPLACE (City and state or country) <b>Irondale, Ohio</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Fred Thompson</b>			13b. MOTHER'S MAIDEN NAME <b>Josie Cummins</b>		14. NAME OF HUSBAND OR WIFE <b>Ralph Moore</b>		
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>-</b>	17. INFORMANT Address <b>Mrs. Norma Lane, 3730 Fuller</b>				
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>Rheumatic heart disease with mitral stenosis and insufficiency</b>						INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</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)						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	
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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>May 21, 1959</b> to <b>July 25, 1959</b> and last saw her alive on <b>July 25, 1959</b> Death occurred at <b>5:45</b> <b>P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>M.D.</b>				22b. ADDRESS <b>Kansas City, Mo</b>			22c. DATE SIGNED <b>7/31/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-1-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Brooking Cemetery</b>		23d. LOCATION (City, town, or county) <b>Leeds, Mo.</b>		(State)
24. FUNERAL DIRECTOR <b>MELLODY-MCGILLEY-EYLAR</b> <b>WOODLAND &amp; LINWOOD</b>				25. DATE RECD. BY LOCAL REG. <b>7-31-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>		

DOCUMENT

BY AFFIDAVIT OF Funeral Home MEDICAL CERTIFICATION

No. 1-2892  
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1-5 Fri

**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 \_\_\_\_\_  
Licensed Embalmer No. 299

P.O. Address \_\_\_\_\_

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