

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS AUG 12 1959**

77

59-025707

Registration District No. 162 Primary Registration District No. 5394 Registrar's No. 162 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jefferson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jeff.</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>House Springs Mo</u>		Length of stay in 1b	c. CITY OR TOWN <u>EUREKA MO</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bynes Mill Road</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RR#1</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph C. Moder</u>			4. DATE OF DEATH Month Day Year <u>8-3-59</u>			
---	--	--	--	--	--	--

5. SEX <u>M</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>10/20/1876</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-----------------	---------------------------	---	------------------------------------	----------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>	11. BIRTHPLACE (City and state or country) <u>Rock Creek, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---	--	--	---

13a. FATHER'S NAME <u>Vince Moder</u>	13b. MOTHER'S MAIDEN NAME <u>MARGARET HILGERT</u>	14. NAME OF HUSBAND OR WIFE <u>KATIE MODER</u>
---------------------------------------	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>KATIE MODER EUREKA MO RR#1</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>Cerebral embolism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>arteriosclerosis + hypertension.</u>	<u>20 years.</u>
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>chronic prostatitis</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
--	--

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.)
--	---	--

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 <u>7-15-59</u> to <u>8-3-59</u> and last saw him alive on <u>8-1-59</u> Death occurred at <u>6:15 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE (Degree or title) <u>[Signature]</u>	22b. ADDRESS <u>Eureka, Mo.</u>	22c. DATE SIGNED <u>8-4-59</u>
---	---------------------------------	--------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/5/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Philomenas Cgm.</u>	23d. LOCATION (City, town, or county) (State) <u>House Springs Mo.</u>
---	-------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS <u>Drummer Funeral Home House Springs Mo</u>	25. DATE RECD. BY LOCAL REG. <u>8-5-59</u>	26. REGISTRAR'S SIGNATURE <u>Robert E. Bauer</u>
---	--	--

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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Elmo D. Godwell

Licensed Embalmer No. 407

P. O. Address St. Louis

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.