IRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS AUG 18 1959

59–029918
STATE FILE NUMBER

Registration District No. 257 Primary Registration District No. 5880 Registrar's No. 58

1. PLACE OF DEATH
a. COUNTY: Osage
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Crawford
Length of stay in 1b: 2 Weeks
c. FULL NAME OF HOSPITAL OR INSTITUTION: Linn Manor Rest Home
Inside Limits: Yes ☐ No ☑

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY: Maries
c. CITY OR TOWN: Meta, Mo.
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): Rt. 2.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Andy Middle: A. Last: Moss
4. DATE OF DEATH: Month Aug. Day 13 Year 1959.
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 1/11/87
9. AGE (last birthday): 72
IF UNDER 1 YEAR: Months 7 Days 2
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (City and state or country): Maries Co. Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: James D. Moss
13b. MOTHER'S MAIDEN NAME: Rachel E. Stevens
14. NAME OF HUSBAND OR WIFE: none
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Ray Moss, Address: Meta, Mo. Rt. 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Medullary Failure — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Thrombosis. — 2 Months
DUE TO (c) Generalized Arteriosclerosis — Years.
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 7-21-59, to 8-13-59 and last saw her/him alive on 8-13-59
Death occurred at 1:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [illegible] M.D.
22b. ADDRESS: Linn, Mo.
22c. DATE SIGNED: 8-15-59

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 8/16/59
23c. NAME OF CEMETERY OR CREMATORY: Carnes Camp Gound
23d. LOCATION (City, town, or county) (State): Boone Twp. Maries Co. Mo
24. FUNERAL DIRECTOR: [illegible]
ADDRESS: Vienna, Mo.
25. DATE RECD. BY LOCAL REG.: 8-15-59
26. REGISTRAR'S SIGNATURE: Mrs Clyde Morton

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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