

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031885

FILED VS OCT 7, 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 71 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Dent</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Dent</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springcreek typ</u>	Length of stay in lb <u>5 hrs</u>	c. CITY OR TOWN <u>Salem</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 mile - Salem H W</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Walker st</u>

3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>A</u> Last <u>Mooney</u>			4. DATE OF DEATH Month <u>9</u> - Day <u>29</u> - Year <u>59</u>		
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</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>6-8-00</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>general work</u>	11. BIRTHPLACE (City and state or country) <u>Dent Co Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
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13a. FATHER'S NAME <u>James Russell Mooney</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Jane Mooney</u>	14. NAME OF HUSBAND OR WIFE <u>Virgie Lunn Mooney</u>
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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>198 01 1202</u>	17. INFORMANT <u>Virgie Mooney</u> Address <u>Salem Mo</u>
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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) <u>Death Due to Natural Causes (Investigated by Coroner)</u>		INTERVAL BETWEEN ONSET AND DEATH
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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 _____
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21. I attended the deceased from 5/12/45 to 7/3/58 and last saw ^{her}him alive on 7/3/58
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>Math M Hart R</u>	22b. ADDRESS <u>Salem, Mo.</u>	22c. DATE SIGNED <u>10/5/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-4-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cem</u>	23d. LOCATION (City, town, or county) <u>Salem Mo</u>
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24. FUNERAL DIRECTOR <u>Spences</u> ADDRESS <u>Salem Mo</u>	25. DATE RECD. BY LOCAL REG. <u>10/5/59</u>	26. REGISTRAR'S SIGNATURE <u>M M Hart, M.D. dau</u>
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DOCUMENT
MEDICAL CERTIFICATION
AFFIDAVIT OF

BOARD OF REGISTRATION
OF EMBALMERS
STATE OF MISSISSIPPI

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 Carl H. Dyer

Licensed Embalmer No. 9376

P. O. Address Polun

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.