

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032776

FILED VS. OCT 15 1959

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. 484

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>JASPER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>JASPER</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JOPLIN</b> Length of stay in 1b <b>5 YR</b>		c. CITY OR TOWN <b>JOPLIN</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>712 POOL</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>712 POOL</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROSELLA</b> Middle <b>MOORE</b> Last			4. DATE OF DEATH Month <b>OCT</b> Day <b>10</b> Year <b>1959</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>20 JAN 1878</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	9. AGE (last birthday) <b>87</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11. BIRTHPLACE (City and state or country) <b>CARTERSVILLE, MO</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>ARON MOODY</b>		13b. MOTHER'S MAIDEN NAME <b>LAURA BRADFORD</b>	14. NAME OF HUSBAND OR WIFE
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.	17. INFORMANT Address

DOCUMENT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>ANURIA - SHOCK.</b>		<b>2 hr</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>myocardial infarction</b>	<b>24 hr.</b>
	DUE TO (c) <b>Coronary occlusion</b>	<b>24 hr.</b>

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
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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. 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
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21. I attended the deceased from **Oct 9 1959** to **Oct 9-1959** and last saw her <sup>her</sup> alive on **Oct 9 1959**  
 Death occurred at **1 AM Oct 10 1959** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>SE Kelburne M.D.</b>	22b. ADDRESS <b>409 W 4th Joplin</b>	22c. DATE SIGNED <b>10/10/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>13 OCT 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GALENA CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>GALENA KAN</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Hulbert Glover, Joplin</b>	25. DATE RECD. BY LOCAL REG. <b>10-12-1959</b>	26. REGISTRAR'S SIGNATURE <b>Dore Merriam</b>
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MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 20 1959

**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 Dale W. [Signature]

Licensed Embalmer No. 459

P. O. Address [Signature]

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.