

# JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-035659

FILED VS NOV 3 1959 096

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 076 Registrar's No. 61

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dallas</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Buffalo</u> Length of stay in 1b <u>23 yrs</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dallas</u> c. CITY OR TOWN <u>Buffalo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>av. main st.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>av. main st.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>av. main st.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <u>EARL</u> Middle <u>Y</u> Last <u>MOULDER</u>			<b>4. DATE OF DEATH</b> Month <u>OCT.</u> Day <u>19</u> Year <u>1959</u>				
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Nov. 22, 1902</u>	<b>9. AGE (last birthday)</b> <u>56 yrs</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>27</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Dr. of Dental Surgery</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Dentist</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>snacks creek, mo.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.</u>	
<b>13a. FATHER'S NAME</b> <u>Newton Moulder</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Jessie Young</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Ruby Moulder</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <u></u>	
<b>16. SOCIAL SECURITY NO.</b> <u></u>		<b>17. INFORMANT</b> Address <u>Ruby Moulder Buffalo, mo.</u>					

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary emphysema, bilateral, severe</u> <u>(2) Pulmonary congestion, chronic</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u> <u>6 mo.</u>
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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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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____					

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	COUNTY	STATE
21. I attended the deceased from <u>7/28/55</u> to <u>10/19/59</u> and last saw <del>him</del> <u>her</u> alive on <u>10/10/59</u> Death occurred at <u>4:15 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

<b>22a. SIGNATURE</b> (Degree or title) <u>John W. Poth, MD</u>	<b>22b. ADDRESS</b> <u>604 Med. Arts Bldg., Springfield, Mo.</u>	<b>22c. DATE SIGNED</b> <u>10/27/59</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>Oct 21, 1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Hope well</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Dallas co., mo.</u>

<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>L. B. Jones Buffalo, mo.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>11/2/59</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Mrs Vera Petree</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 me  
or by                     *me*                    , Student Embalmer No.                     *✓*                      
working under my personal supervision.

Student                     *✓*                      
Signature of Student Embalmer

Signed                     *R-E. Cheatham*                    

Licensed Embalmer No.                     *3813*                    

P. O. Address                     *Buffalo, N.Y.*                    

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.