

FILED VS DEC 9 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-039284

STATE FILE NUMBER

Registration District No. 59 Primary Registration District No. _____ Registrar's No. 186

1. PLACE OF DEATH a. COUNTY <u>Cass</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Belton</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Belton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>105 Hollywood</u>			Length of stay in lb <u>LIFE</u>	d. STREET ADDRESS (If outside, give location) <u>105 Hollywood</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>DAVID</u> Last <u>MOORE</u>				4. DATE OF DEATH Month <u>Nov</u> ; Day <u>27</u> , Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-20-56</u>	9. AGE (In years last birthday) <u>3</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Kansas City Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Charles Robert Moore</u>			13b. MOTHER'S MAIDEN NAME <u>Betty L. Zuberbier</u>			14. NAME OF HUSBAND OR WIFE <u>None</u>		
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>None</u>		17. INFORMANT <u>Robert F. Moore, Belton Missouri</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>Gunshot wound, right post-auricular head area</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Instantaneous</u>		
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)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Gunshot wound, through + through, head, behind right ear.</u>					
20c. TIME OF INJURY Hour <u>10:30</u> Month <u>11</u> , Day <u>27</u> , Year <u>59</u> p.m.			20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>BELTON</u> COUNTY <u>CASS</u> STATE <u>MO.</u>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on <u>not seen alive</u> Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Herbert G. Tracy, M.D.</u> (Degree or title)				22b. ADDRESS <u>BELTON, Mo.</u>		22c. DATE SIGNED <u>11-28-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/1/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Benton Green</u>		23d. LOCATION (City, town, or county) (State) <u>Osceola Missouri</u>			
24. FUNERAL DIRECTOR <u>Goodrich Funeral Home, Osceola Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>12-3-59</u>		26. REGISTRAR'S SIGNATURE <u>Mrs Ray Sebra</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

VS SEP 6 1960

APR 1 9 1960

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *J.B. [Signature]*

Licensed Embalmer No. *3038*

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.