

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001762

FILED VS FEB 1 1960

149 Primary Registration District No. 1002

342

STATE FILE NUMBER

Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b 28 years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		d. STREET ADDRESS (If outside, give location) 3414 Penn.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Raymond Middle F. Last Moore			4. DATE OF DEATH Month 1 Day 20 Year 1960			
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH JULY 1, 1909	9. AGE (last birthday) 50	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		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) Manager	10b. KIND OF BUSINESS OR INDUSTRY Laundry	11. BIRTHPLACE (City and state or country) Dallas Texas	12. CITIZEN OF WHAT COUNTRY U.S.
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13a. FATHER'S NAME MAURFEESE M. MOORE	13b. MOTHER'S MAIDEN NAME ALIDA B. YALLNER	14. NAME OF HUSBAND OR WIFE Iola Moore
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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) no	16. SOCIAL SECURITY NO. 486-07-4687	17. INFORMANT Address Wife Iola Moore 3414 Penn
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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) Lambled pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3-4 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Atherosclerosis of Ott. coron		3 MO
	DUE TO (c) Colletery		1 MO

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 checked="" 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 _____

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 **11-10-59** to **1-26-60** and last saw him alive on **1-19-60**
Death occurred at **430 A.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John T. Skinner MD	22b. ADDRESS 1102 Grand K. C. MO	22c. DATE SIGNED 1-20-60
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23a. BURIAL, EMBALMENT, REMOVAL (Specify) Burial	23b. DATE 1-22-60	23c. NAME OF CEMETERY OR CREMATORY MT OLIVET	23d. LOCATION (City, town, or county) (State) K. C. MO
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24. FUNERAL DIRECTOR ADDRESS Melody-McGilley-Eylar 20 W. Linwood K.C. Mo.	25. DATE RECD. BY LOCAL REG. 1-20-60	26. REGISTRAR'S SIGNATURE Neve Minshall
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BY AFFIDAVIT OF JOHN T. SKINNER MEDICAL CERTIFICATION DOCUMENT

Dr. J. T. S.
August

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 W. A. Kenly

Licensed Embalmer No. 0509

P. O. Address K. C. M.

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.