

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**60-022393**  
STATE FILE NUMBER

FILED VS JUN 20 1960

042

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

ENDED

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Buchanan</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b <b>7yrs</b>		c. CITY OR TOWN <b>St. Joseph,</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Rt #3,</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>Rt #3,</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Alpha</b> Middle <b>M</b> Last <b>Moon</b>				4. DATE OF DEATH Month <b>June</b> Day <b>8,</b> Year <b>1960</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>Nov 15, 1890</b>	9. AGE (last birthday) <b>69</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House keeper</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Breckinridge, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>John Lett</b>			13b. MOTHER'S MAIDEN NAME <b>Emma Lucas</b>			14. NAME OF HUSBAND OR WIFE <b>Wm. G. Moon, (de)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>D</b> Address <b>enjamin Moon St. Joeph, Mo</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral hemorrhage</b>							INTERVAL BETWEEN ONSET AND DEATH <b>17 days</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>hypertension</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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. _____ 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	
21. I attended the deceased from <b>5/23/60</b> to <b>6/8/60</b> and last saw her alive on <b>6/6/60</b>				Death occurred at <b>1:30 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>John Spencer D.O.</b>			22b. ADDRESS <b>224 Kirkpatrick Bldg.</b>			22c. DATE SIGNED <b>6/10/60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/10/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo</b>				
24. FUNERAL DIRECTOR <b>John Rupp</b>			ADDRESS <b>St. Joseph, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>June 14, 1960</b>		26. REGISTRAR'S SIGNATURE <b>Mr. Clark Standell</b>		

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

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*John E. Rupp*

Licensed Embalmer No. 3986

P. O. Address St. Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.