

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-038845

FILED VS. NOV. 1 1960

165

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STATE FILE NUMBER

| | | | | | | | |
|--|--|---|--|--|---|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | |
| a. COUNTY <u>Johnson</u> | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Knobroster</u> | | a. STATE <u>Mo</u> | | b. COUNTY <u>Johnson</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R.F.D # 2</u> | | Length of stay in lb <u>22 yrs</u> | | c. CITY OR TOWN <u>Knobroster</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>R.F.D # 2</u> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | | | 4. DATE OF DEATH | | | |
| First <u>Elizabeth</u> | | Middle <u>Theadocia</u> | | Last <u>Moore</u> | | Month <u>Nov</u> Day <u>3</u> Year <u>1960</u> | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1-23-1874</u> | |
| | | | | 9. AGE (last birthday) <u>86</u> | | 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) <u>Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (City and state or country) <u>Blackwater Lee Co. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>Eli Brewer</u> | | | 13b. MOTHER'S MAIDEN NAME <u>unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>Robert Moore Sr.</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>Albert Moore</u> | | Address <u>Knobroster R # 2</u> | |
| 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) <u>Ingestion</u> | | | | | | <u>1 week</u> | |
| DUE TO (b) <u>Seizure</u> | | | | | | <u>Years</u> | |
| DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) | | | | | | 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 | |
| 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 <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u> | | 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 <u>10-12-51</u> to <u>11-4-60</u> and last saw her/him alive on <u>11-1-60</u> . Death occurred at <u>9:05 PM.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>[Signature]</u> | | | | 22b. ADDRESS <u>Warrsburg, Mo</u> | | 22c. DATE SIGNED <u>11/5/60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>11-7-60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u> | | 23d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>M^cLaughlin Bros Sedalia</u> | | | 25. DATE RECD. BY LOCAL REG. <u>11/12/60</u> | | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | |

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 *KPM Cray*

Licensed Embalmer No. 31530

P. O. Address Sedale

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.