

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-009008

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1519 STATE FILE NUMBER

FILED APR 10 1961

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Wyandotte				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 6 1/2 years		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Woodland Nursing Home INSTITUTION 512 Woodland Avenue				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2814 S. 37th Street		
3. NAME OF DECEASED (Type or print) First IDA Middle J Last MOYER				4. DATE OF DEATH Month March Day 25 Year 1961				
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10/21/90		
				9. AGE (last birthday) 71		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (City and state or country) Fayette, Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME James Robert Dodson				13b. MOTHER'S MAIDEN NAME Lucinde Wilsoxon		14. NAME OF HUSBAND OR WIFE Allen Jacob Moyer		
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.		17. INFORMANT Address Wilbur W. Mason, 2814 S. 37th KCK		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS							INTERVAL BETWEEN ONSET AND DEATH 48 hrs.	
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)						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 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 <u>Sept. 1960</u> to <u>3/25/61</u> and last saw her/him alive on <u>3/24/61</u> Death occurred at <u>12:15 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Leo F. Cooper M.D.				22b. ADDRESS 1220 E. 31st KC Mo		22c. DATE SIGNED 3-25-61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 27, 61		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri		
24. FUNERAL DIRECTOR D.W. Newcomer's Sons, K.C. Missouri			25. DATE RECD. BY LOCAL REG. 3-26-61		26. REGISTRAR'S SIGNATURE Keith Long			

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.