

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1925 STATE FILE NUMBER -61-013887

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 13 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 INSTITUTION 5223 WOODLAND AVENUE		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5223 WOODLAND AVE. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First WEBER Middle (NONE) Last MOORE			4. DATE OF DEATH Month 4 Day 15 Year 61			
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-17-91	9. AGE (last birthday) 69	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) ACCOUNTANT		10b. KIND OF BUSINESS OR INDUSTRY SKELLY OIL CO		11. BIRTHPLACE (City and state or country) LIBERTY, MO.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME HENRY RICHARD MOORE			13b. MOTHER'S MAIDEN NAME ELIZABETH WEBER			14. NAME OF HUSBAND WIFE ESTHER I. MOORE	
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 KANSAS CITY, MO. MRS. ESTHER I. MOORE, 5223 WOODLAND		

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) Coma due to Uremia & Acidosis		27 Hrs.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Chronic Azotemia - end stage kidney		2 Years.
	DUE TO (c) Diabetic Nephropathy.		5 Years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1) Diabetes mellitus. 2) General, Cerebral & Coronary Arteriosclerosis			PART III. If deceased was female was there a pregnancy in last 90 days. <input checked="" type="checkbox"/> Yes <input 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
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21. I attended the deceased from **Dec. 1957** to **15 April 1960** and last saw ^{her}him alive on **15 April 1960**.
Death occurred at **9:45 Pm** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Philip Kaul M.D.		22b. ADDRESS 711 Nichols Rd		22c. DATE SIGNED 4-17-1961
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE APR. 19, 61	23c. NAME OF CEMETERY OR CREMATORY 1111111	23d. LOCATION (City, town, or county) (State) PAOLA KANSAS	

24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS KANSAS CITY, MO.		25. DATE RECD. BY LOCAL REG. 4-19-61	26. REGISTRAR'S SIGNATURE Ruth Long
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

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 Chester K Brown

Licensed Embalmer No. 4931

P. O. Address KE MD

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.