

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-017020

STATE FILE NUMBER

Registration District No. 116 Primary Registration District No. 3020 Registrar's No. 137

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED JUN 5 1961

1. PLACE OF DEATH
 a. COUNTY FRANKLIN
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WASHINGTON Length of stay in 1b 1 DAY
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. FRANCIS Hosp Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE MISSOURI b. COUNTY FRANKLIN
 c. CITY OR TOWN SULLIVAN Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) OLSEN REST HOME Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last (Type or print) CHARLES LEE MOSS
 4. DATE OF DEATH Month Day Year MAY 29 1961

5. SEX MALE 6. COLOR OR RACE WHITE 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH AUG 25, 1877 9. AGE (last birthday) 83 IF UNDER 1 YEAR IF UNDER 24 HR
 Months Days Hours Min. 9 4

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER & FARMING 10b. KIND OF BUSINESS OR INDUSTRY FARM 11. BIRTHPLACE (City and state or country) CRAWFORD Co., Mo. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME DANIEL MOSS 13b. MOTHER'S MAIDEN NAME TELITHA 14. NAME OF HUSBAND OR WIFE BERTHA BRANDT

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. NONE 17. INFORMANT VICTOR MOSS Address SULLIVAN, MO.

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
 DUE TO (b) ARTERIOSCLEROSIS
 DUE TO (c) _____
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PNEUMONIA
 PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes N. Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
 20c. TIME OF INJURY Hour _____ Month, Day, Year _____
 20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 1958 to 1961 and last saw him alive on May 28-1961
 Death occurred at 7:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert M. Crawford MD 22b. ADDRESS Sullivan Mo. 22c. DATE SIGNED May 29 1961

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE MAY 30, 1961 23c. NAME OF CEMETERY OR CREMATORY P.O.O.F. CEMETERY 23d. LOCATION (City, town, or county) (State) SULLIVAN MO

24. FUNERAL DIRECTOR H.M. EATON, SULLIVAN, MO. ADDRESS _____ 25. DATE RECD. BY LOCAL REG. 5/30/61 26. REGISTRAR'S SIGNATURE Paul C. Sullivan

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 *Yauson Jr. Eaton*

Licensed Embalmer No. 5066

P. O. Address *Sullivan, Mo*

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.