

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-030505

STATE FILE NUMBER

AMENDED

Registration District No. 316 Primary Registration District No. _____ Registrar's No. 325

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>St Francois</u>	a. STATE <u>Missouri</u>	b. COUNTY <u>Crawford</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Farmington</u>	Length of stay in 1b <u>5 yrs 9 mos</u>	c. CITY OR TOWN <u>Cuba</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>state Hosp # 4</u>	Inside Limits <u>No</u>	d. STREET ADDRESS (If outside, give location) <u>506 N. Oakhill Rd.</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First <u>Daniel</u>	Middle <u>J.</u>	Last <u>Moody</u>	Month <u>Aug.</u>	Day <u>12</u>	Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 14 1922</u>	9. AGE (last birthday) <u>38</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>23</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus boy Chase Hotel</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and state or country) <u>St Louis, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James S. Moody</u>		13b. MOTHER'S MAIDEN NAME <u>Ellen Kronenburger</u>		14. NAME OF HUSBAND OR WIFE <u>Never married</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>NIL</u>		17. INFORMANT <u>William Moody Jefferson City, Mo</u>		Address <u>405 Church</u>	
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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>Terminal pneumonia</u>			<u>24 hrs.</u>
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) <u>Chronic brain syndrome associated with convulsive disorder with psychotic reaction, and tuberculosis.</u>		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	
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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 checked="" 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 Nov. 10, 1955 to Aug. 12, 1961 and last saw him live on 8-12-61
Death occurred at 1:15 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>C. J. Hoener</u> (Degree or title)	22b. ADDRESS <u>State Hospital No. 4 Farmington, Missouri</u>	22c. DATE SIGNED <u>8-13-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE <u>Aug 14, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>	23d. LOCATION (City, town, or county) <u>Cuba</u>	23e. STATE <u>MO</u>
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24. FUNERAL DIRECTOR <u>Norman C. Hoener</u>	ADDRESS <u>Cuba, MO</u>	25. DATE RECD. BY LOCAL REG. <u>Aug. 13, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Esther Rudloff</u>
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DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

AUG 25 1961

AUG 29 1961

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 Norman P. Keener

Licensed Embalmer No. 4673

P. O. Address Cuba, 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.