

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041559
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE
 Registration District No. 170 Primary Registration District No. _____ Registrar's No. 204

DATE AMENDED	FILED DEC 5 1961														
INSTEAD OF	1. PLACE OF DEATH a. COUNTY <u>Laclede</u>						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>								
DOCUMENT	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Oakland Twp.</u>				Length of stay in 1b <u>1 yr.</u>		c. CITY OR TOWN <u>Lebanon</u>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
MEDICAL CERTIFICATION	c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Plato Star Rt. Lebanon</u>						Side Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Plato Star Rt.</u>				Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
SHOULD READ	3. NAME OF DECEASED (Type or print) First Middle Last <u>Della May Moorhouse</u>						4. DATE OF DEATH Month Day Year <u>Nov. 23, 1961</u>								
BY AFFIDAVIT OF	5. SEX <u>7</u>		6. COLOR OR RACE <u>white</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7/10/1894</u>		9. AGE (last birthday) <u>67</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR		
SHOULD READ	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (City and state or country) <u>Springfield, Mo. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY				
SHOULD READ	13a. FATHER'S NAME <u>George W. Coons</u>				13b. MOTHER'S MAIDEN NAME <u>Ida Anderson</u>				14. NAME OF HUSBAND OR WIFE <u>John J. Moorhouse</u>						
SHOULD READ	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>-</u>		17. INFORMANT <u>Mrs. James Proctor Lebanon Mo</u>						
SHOULD READ	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:														
SHOULD READ	IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>				
SHOULD READ	Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u> years														
SHOULD READ	DUE TO (c) <u>Diabetes mellitus</u> years														
SHOULD READ	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture of hip about 2 yrs. ago</u>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						
SHOULD READ	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.)										
SHOULD READ	20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.														
SHOULD READ	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		
SHOULD READ	21. I attended the deceased from <u>9-22-61</u> to <u>11-23-61</u> and last saw her ^{her} alive on <u>11-20-61</u> Death occurred at <u>5:30 A.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.														
SHOULD READ	22a. SIGNATURE (Degree or title) <u>B. Hurst, M.D.</u>						22b. ADDRESS <u>Lebanon, Mo.</u>			22c. DATE SIGNED <u>11-27-61</u>					
SHOULD READ	23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11/25/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Hope Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>near Long Lane Mo.</u>							
SHOULD READ	24. FUNERAL DIRECTOR <u>Dorsey M. Howe Lebanon Mo.</u>				ADDRESS <u>Lebanon Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-27-1961</u>		26. REGISTRAR'S SIGNATURE <u>Della L. Hays</u>						

VS DEC 11 1961

DEC 29 1961

VS DEC 11 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 Dorsey M. Hou

Licensed Embalmer No. 422

P. O. Address Lebanon

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.