

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045853

STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 153

FILED JAN 8 1962

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>I.</u> b. COUNTY <u>Bristol</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Waynesville</u>		Length of stay in 1b <u>6 hrs</u>	c. CITY OR TOWN <u>Warren</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>Pulaski Co Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Bagy Wrinkle Cove</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gail</u> Middle <u>Ann</u> Last <u>Moses</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>Female</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>Apr 23 1936</u>	9. AGE (last birthday) <u>25</u>	IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Bronxville N Y</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Harlan T Moses</u>		13b. MOTHER'S MAIDEN NAME <u>Sheila Hartwell</u>		14. NAME OF HUSBAND OR WIFE <u>None</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>			17. INFORMANT Address <u>Harlan T Moses Warren R I</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural hemorrhage</u> DUE TO (b) <u>Gunshot wound to brain</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>8-12 hrs</u> <u>8-12 hrs</u>	
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Self inflicted.</u>				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <u>12 15 1961</u>		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.) <u>motel</u>	20f. CITY, TOWN, OR LOCATION <u>Waynesville</u>	COUNTY <u>Pulaski</u>	
20f. STATE <u>MO</u>	21. I attended the deceased from <u>12-15-61</u> to <u>12-15-61</u> and last saw her alive on <u>12-15-61</u> Death occurred at <u>5:45 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Deceased or Affiant) <u>[Signature]</u>			22b. ADDRESS <u>Waynesville Missouri</u>		22c. DATE SIGNED <u>12/16/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12/17/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Swan Point Cemetery</u>	23d. LOCATION (City, town, or county) <u>Providence R I</u>	23e. STATE <u>(State)</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Moss-Williams Funeral Homes Crocker</u>		25. DATE REC'D. BY LOCAL REG. <u>12-17-61</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

7961 JAN 5 SA

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 Clarice Moss

Licensed Embalmer No. 4896

P. O. Address Waynesville, N.C.

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.