

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-001897

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 1002 Primary Registration District No. 1002 Registrar's No. 160

STATE FILE NUMBER

AMENDED

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>2 Mos.</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Wheatley Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2513 Norton</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Statsie</b> Middle <b>Mosley</b> Last <b>Mosley</b>	4. DATE OF DEATH Month <b>1</b> Day <b>10</b> Year <b>62</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-22-89</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months <b>72</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (City and state or country) <b>Mound City, Ill.</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Thomas Mosley</b>	13b. MOTHER'S MAIDEN NAME <b>Josephine Hunt</b>	14. NAME OF HUSBAND OR WIFE <b>Ihez Mosley</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>xxx No None</b>	17. INFORMANT Address <b>Mrs. Geneva Lang, 2513 Norton</b>
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18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Septicemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
DUE TO (b) <b>Renal Failure</b>		
DUE TO (c) _____		<b>4 days</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Recurrent Cerebral Thrombosis</b>	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.) <b>none</b>
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20c. TIME OF INJURY <b>none</b>	Hour _____ a.m. _____ p.m.	Month _____ Day _____ Year _____
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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.) <b>none</b>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>KANSAS CITY, Jackson, MO</b>
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21. I attended the deceased from <b>18 Nov 62</b> and last saw him alive on <b>29 Jan 62</b> Death occurred at <b>8:50 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>John H. Wells MD</b>	22b. ADDRESS <b>3718 Prospect</b>	22c. DATE SIGNED <b>11 Jan 62</b>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1-12-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City</b>	23d. LOCATION (City, town, or county) (State) <b>Carbondale, Illinois</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Jones &amp; Stevens 2315 Linwood Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>1-11-62</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 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 \_\_\_\_\_

Licensed Embalmer No. 4429

P. O. Address 2315 Linwood  
1500

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.