

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-049448

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6725

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 21 1963

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Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Jackson</u>		a. STATE <u>Kansas</u> b. COUNTY <u>Wyandotte</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay in 1b <u>5 days</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>St. Lukes Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>1983 Stewart</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Agnes Moffatt</u>			4. DATE OF DEATH Month Day Year <u>12-31-1962</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-1875</u>
9. AGE (last birthday) <u>87</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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>home</u>	11. BIRTHPLACE (City and state or country) <u>Leavenworth, Kns.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Unknown</u>	
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Kenmuir Moffatt</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>none</u>	17. INFORMANT Address <u>Mrs. L.W. DeYong K.C. Mo.</u>
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>Acute Bronchopneumonia - bilateral</u>			<u>7 days</u>
DUE TO (b) <u>Intertrochanteric fracture of the femur</u>			
DUE TO (c) _____			
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
<u>Generalized arteriosclerosis with extensive Cerebral Arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <u>Fell(?) while using a commode</u>	
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.) <u>Nursing Home</u>	20f. CITY, TOWN, OR LOCATION <u>Kansas City</u>	COUNTY <u>Jackson</u> STATE <u>Mo.</u>
21. I attended the deceased from <u>11-11-59</u> to <u>12-31-62</u> and last saw her/him alive on <u>12-31-62</u>			
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>M.D. 4320 Wornall Road, K. C. Mo.</u>	22c. DATE SIGNED <u>1-2-63</u>
23a. BURIAL, CREMATION, (Specify) <u>Burial</u>	23b. DATE <u>1-3-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Kansas</u>
24. FUNERAL DIRECTOR ADDRESS <u>R.A. Fulton, Kansas City, Kansas</u>		25. DATE RECD. BY LOCAL REG. <u>1-2-63</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

John Wheeler -
4320 Wornall Rd. -

JE 1-2338-

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 Ralph Fulton

Licensed Embalmer No. 0035

P. O. Address K.C. 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.