

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. _____

Registrar's No. 4373

LED NOV 1 1943 149
Registration District No. _____

Primary Registration District No. 1002

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Menorah Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 11 Days
 In this community 60 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 4909 Bellefontaine Avenue
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mr. Moad Robert Southard
 3. (b) If veteran, name war No
 3. (c) Social Security No. None
 4. Sex Male
 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Mrs. Victoria I. Southard
 6. (c) Age of husband or wife if alive 76 years
 7. Birth date of deceased April 4 1869
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month October day 12th
 year 1943 hour 5 minute 15 P. M.
 21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him alive on Oct 12, 1943
 and that death occurred on the date and hour stated above.

8. AGE: Years 74 Months 6 Days 8
 If less than one day _____ hr. _____ min.
 9. Birthplace Leavenworth County Kansas
(City, town, or county) (State or foreign country)

Immediate cause of death Atherosclerosis - Myocarditis - Senility
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

MOTHER FATHER
 10. Usual occupation Retired
 11. Industry or business Feed & Milling Business
 12. Name Wesley Southard
 13. Birthplace Carolina
(City, town, or county) (State or foreign country)
 14. Maiden name Eleanor Postick
 15. Birthplace Kentucky
(City, town, or county) (State or foreign country)
 16. (a) Informant Mrs. Victoria I. Southard
 (b) Address 4909 Bellefontaine
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15 43
(Month) (Day) (Year)
 (c) Place: burial or cremation Forest Hill
 18. (a) Signature of funeral director D. H. Newcomer, Inc.
 (b) Address 1401 Brush Creek Blvd.
 19. (a) 10-14-43 (Date received local registrar) (b) P. E. Brown (Registrar's signature)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
 While at work? _____ (Specify type of place) (c) Means of injury _____
 23. Signature Alabam Sophia (M. D. or other) _____
 Address 1405 Bryant Bldg Date signed Oct-13/43

Duration many years
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

C - BLACK INK - MAKE A PERMANENT RECORD

WRITE PLAINLY

1400-1000-1000-1000

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *R C Mc*

Licensed Embalmer No. 4043

P. O. Address *R C Mc*

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 this body is not embalmed, fact should be so stated above.