

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

1837

State File No.

BIRTH NO. FILED FEB 15 1954 REG. DIST. NO. 167 PRIMARY REG. DIST. NO. 4256 Registrar's No. 3

1. PLACE OF DEATH a. COUNTY Johnson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Johnson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Holden		c. LENGTH OF STAY (in this place) Life.	
d. FULL NAME OF HOSPITAL OR INSTITUTION South Main Street		d. STREET ADDRESS (If rural, give location) South Main Street	

3. NAME OF DECEASED (Type or Print) a. (First) Marguerite b. (Middle) LaVerne c. (Last) Mooney			4. DATE OF DEATH (Month) (Day) (Year) Jan 26, 1954		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH July 25, 1898	9. AGE (In years last birthday) 55	10. UNDER 1 YEAR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory worker		10b. KIND OF BUSINESS OR INDUSTRY Clothing	11. BIRTHPLACE (City and State or Foreign Country) Holden, Missouri		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Michael J. Mooney	13b. MOTHER'S MAIDEN NAME Laura McClain	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 500-10-7559	17. INFORMANT'S SIGNATURE OR NAME Tom Mooney, Holden, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinomatosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Primary in fundus Uteri DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? 172 X YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-15, 1954, to 1-26, 1954, that I last saw the deceased alive on 1-26, 1954, and that death occurred at 11:30 Am., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Kelly Paulins M.D.	23b. ADDRESS Holden Mo	23c. DATE SIGNED 1/27/54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-30-1954	24c. NAME OF CEMETERY OR CREMATORY Holden Cemetery
		24d. LOCATION (City, town, or county) (State) Holden, Mo.

DATE REC'D BY LOCAL REG. 2-2-54	REGISTRAR'S SIGNATURE Mrs G. V. Redford	25. FUNERAL DIRECTOR'S SIGNATURE E. B. CAST, HOLDEN MO	ADDRESS Blank
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10-48

0510

0510

0510

RECEIVED
FEB 8 1954

JOHNSON CO. HEALTH DEPT.
COURT HOUSE
WARRENSBURG, MISSOURI

FEB 15 1954

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
Student Embalmer

Signed

EB Cast

Licensed Embalmer No. 4059

P. O. Address Holden, 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 this body is not embalmed, fact should be so stated above.