

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18851**
2276

FILED JUN 16 1955

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2276

1. PLACE OF DEATH a. COUNTY <u>Johnson Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>VERNON</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City, Mo.</u>		c. CITY OR TOWN <u>TRUADA</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>6 weeks</u>		STREET ADDRESS (If rural, give location) <u>1203 West Ashland</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Luke's</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>FRED</u>	b. (Middle) <u>STANDLEE</u>	c. (Last) <u>MOORE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>May 26 1955</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>never married</u>	8. DATE OF BIRTH <u>2-5-31</u>	9. AGE (In years last birthday) <u>24</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Nevada Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Walter M. Moore</u>	13b. MOTHER'S MAIDEN NAME <u>Mildred Woodward</u>	14. NAME OF HUSBAND OR WIFE <u>-</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>490-32-9481</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Walter M. Moore</u>	ADDRESS <u>1203 W. Ashland</u>
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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 <u>5 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Orogenic Meningitis</u>		
	ANTECEDENT CAUSES DUE TO (b) <u>Chronic otitis media right.</u>		
	DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>3912</u>

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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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) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from March, 1955 to death, 1955, that I last saw the deceased alive on 5-25, 1955, and that death occurred at 3:15 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Williston P. Bunting M.D.</u>	23b. ADDRESS <u>305 W 43 (Conservatory)</u>	23c. DATE SIGNED <u>5-25-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>5-28-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Moore Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Nevada Mo.</u>
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DATE REC'D BY LOCAL REG. <u>5-26-55</u>	REGISTRAR'S SIGNATURE <u>Neva Marshall</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Ferry Funeral Home Nevada, Mo.</u>	ADDRESS _____
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Williston P. Bunting

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.....
P. O. Address.....

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.