

FILED NOV 25 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36244**

BIRTH NO. _____ REG. DIST. NO. **62** PRIMARY REG. DIST. NO. **5238** Registrar's No. **34**

1. PLACE OF DEATH a. COUNTY Cedar		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cedar	
b. CITY (If outside corporate limits, write RURAL and give town or township) Rural, Jefferson		c. CITY (If outside corporate limits, write RURAL and give township) Rural, Jefferson, Township	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 0200	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) Moseley c. (Last) Moseley			4. DATE OF DEATH (Month) (Day) (Year) Nov 18 1955		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 15 1892	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months 0 Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Clay City, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John Bates	13b. MOTHER'S MAIDEN NAME Cora Boyd	14. NAME OF HUSBAND OR WIFE Lawrence Moseley
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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) No	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Lawrence Moseley, Dunnegan, 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, assthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute heart failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic myocarditis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4222			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **11-14 1955**, to **11-18 1955**, that I last saw the deceased alive on **11-14 1955**, and that death occurred at **49 m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) D C McCrean MD	23b. ADDRESS Balvora Mo	23c. DATE SIGNED 11-19-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 11-18 1955	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Clay City, Illinois
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DATE REC'D BY LOCAL REG. 11-19-55	REGISTRAR'S SIGNATURE Geneva Garrison	25. FUNERAL DIRECTOR'S SIGNATURE Barker-Erwin-Blue ADDRESS Fair Play, Mo.
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(Licensed Embalmer's Statement on Reverse Side) By **Frank W. Barker**

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

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 _____

Chas J. Costa

Licensed Embalmer No. _____

4/54

P. O. Address _____

Bolivar, 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.