

FILED JUL 31 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25715**

BIRTH NO. _____ REG. DIST. NO. **337** PRIMARY REG. DIST. NO. **6139** Registrar's No. **44**

1. PLACE OF DEATH a. COUNTY SHELBY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MO b. COUNTY Shelby	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SHELBYVILLE		c. LENGTH OF STAY (in this place) 2 Mo	c. CITY OR TOWN Shelbyville
d. FULL NAME OF HOSPITAL OR INSTITUTION PLEASANT HILL Rest Home		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
		STREET ADDRESS (If rural, give location) 1020	

3. NAME OF DECEASED (Type or Print) a. (First) DANIEL	b. (Middle) BOONE	c. (Last) MOSS	4. DATE OF DEATH (Month) (Day) (Year) 7-21-56
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 6-9-1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Doctor		10b. KIND OF BUSINESS OR INDUSTRY Doctor	9. AGE (In years last birthday) 84
11. BIRTHPLACE (City and State or Foreign Country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME RESON MOSS	13b. MOTHER'S MAIDEN NAME ELIZABETH BOONE	14. NAME OF HUSBAND OR WIFE Mrs. D. B. MOSS
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. NO	17. INFORMANT'S SIGNATURE OR NAME Mrs. D. B. Moss ADDRESS PALMYRA MO

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial degeneration	ANTECEDENT CAUSES (b) Arteriosclerosis		?
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	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? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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) 4221
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 **June 10, 1956**, to **July 21, 1956** that I last saw the deceased alive on **July 16, 1956**, and that death occurred at **9:25 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE P. C. Weaver MD (Degree or title)	23b. ADDRESS Shelbyville MO	23c. DATE SIGNED 7-21-56
24a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	24b. DATE 7-25-56	24c. NAME OF GEMETERY OR CREMATORY KALHALL
24d. LOCATION (City, town, or county) (State) ST. LOUIS MO	24e. REGISTERAR'S SIGNATURE Ada Garrison E. OF FURNERAL DIRECTOR'S SIGNATURE C. J. Snygar ADDRESS PALMYRA MO	
DATE REC'D BY LOCAL REG. 7-24-56		

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

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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.....
E. J. Sprague

Licensed Embalmer No. *3275*

P. O. Address *Palmyra, W.*

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.