

FILED OCT 24 1957

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 4619

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <b>Missouri</b> b. COUNTY <b>Newton</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Neosho</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <b>St. Marie Hosp</b> Length of stay in lb <b>9 Days</b>		d. STREET ADDRESS (If outside, give location) <b>528 W. Spring</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Owen Moss</b> First Middle Last			4. DATE OF DEATH <b>Oct 5 1957</b> Month Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 28 1898</b>
9. AGE (In years last birthday) <b>59</b>	IF UNDER 1 YEAR Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>	11. BIRTHPLACE (City and state or country) <b>Anderson Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	13a. FATHER'S NAME <b>Fred S. Moss</b>		
13b. MOTHER'S MAIDEN NAME <b>Annie Cornell</b>		14. NAME OF HUSBAND OR WIFE <b>Gladys M. Moss</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT <b>Gladys Moss, Neosho, Mo.</b> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Broncho-Pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>DUE TO (b) Intra-Ventricular Hemorrhage</b>			<b>9 days</b>
<b>etiology undetermined</b>			<b>331+</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I (a))			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <b>Sept 26 1957</b> to <b>Oct 5 1957</b> and last saw him alive on <b>10-5-57</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>L. F. Steffen M.D.</b> (Degree or title)		22b. ADDRESS <b>1103 Grand Ave K.C. Mo.</b>	22c. DATE SIGNED <b>10-5-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10-6-57</b>	23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION (City, town, or county) <b>Anderson, Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>Depp Mortuary, Anderson, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>10-5-57</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

L. F. Steffen

KP

OCT 25 1957

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 *John R. Sidmon*

Licensed Embalmer No. *4531*

P. O. Address *Kansas City, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.