

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032222

STATE FILE NUMBER

FILED SEP 22 1958

Registration District No. 100 Primary Registration District No. 5390 Registrar's No. 78

300
1-57

1. PLACE OF DEATH a. COUNTY DENT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY DENT	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN W. SPRINGCREEK TWSP		c. CITY OR TOWN W. SPRINGCREEK TWSP	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Route 2, Salem, Mo		d. STREET ADDRESS (If outside, give location) Rte 2, Salem, Mo.	

3. NAME OF DECEASED (Type or print) First Middle Last JULIA BELLE MOSES			4. DATE OF DEATH Month Day Year SEPT. 19 1958		
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 28 1867	9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HO USEWIFE	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and state or country) DENT COUNTY, MISSOURI	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME HARVEY MCDONALD	13b. MOTHER'S MAIDEN NAME SARAH JANE BLACKWELL	14. NAME OF HUSBAND OR WIFE GEORGE W. MOSES (DECD)
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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 Ella Stricklin, Rte 2, Salem, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial failure		INTERVAL BETWEEN ONSET AND DEATH 6 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) chronic myocarditis	
	DUE TO (c) severe arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4221		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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from 1942 to 9-19-55 and last saw her alive on 9-19-55 Death occurred at 10:00 a m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE Jas D. Warfel, D.D. 2	22b. ADDRESS Salem, Mo.	22c. DATE SIGNED 9-20-58
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23a. BURIAL (CREMATION, REMOVAL) (Specify) BURIAL	23b. DATE SEPT 21, 1958	23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cem.	23d. LOCATION (City, town, or county) (State) Salem Missouri
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24. FUNERAL DIRECTOR Max L. Warfel ADDRESS Salem, Mo.	25. DATE RECD. BY LOCAL REG. Sept. 20, 1958	26. REGISTRAR'S SIGNATURE M. M. Hart, M. D. L. P.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 Max R. Waigel

Licensed Embalmer No. 4170
P. O. Address Salem, N.J.

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.