

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-040990
STATE FILE NUMBER

84184-58
FILED NOV 17 1958 Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 433

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		c. CITY OR TOWN <u>Sedalia</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>520 No MONTEAU</u>	
3. NAME OF DECEASED (Type or print) First <u>Infant DANNY</u> Middle <u>Moye</u> Last <u>Moye</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>11</u> Year <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-31-58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Sedalia Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Robert Moye</u>	
13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT 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) <u>Atele etasis - Broncho Pneumonia</u> DUE TO (b) <u>Prematurity</u> DUE TO (c) <u>6 1/2 Mo Infant</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
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 WORK <input type="checkbox"/> NOT WHILE 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 <u>10-31-58</u> to <u>11-11-58</u> and last saw him alive on <u>11-11-58</u> Death occurred at <u>11-11-58 11:30</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>A. C. Maddox, M.D.</u>		22b. ADDRESS <u>Sedalia Mo</u>	22c. DATE SIGNED <u>11-13-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov 13-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u>
24. FUNERAL DIRECTOR <u>Bothwell Mem. Hospital</u> By <u>Drene Spears</u>		25. DATE RECD. BY LOCAL REG. <u>Nov 13, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>

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 traced. 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. Not Embalmed

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.