

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009570
STATE FILE NUMBER

MAR 19 1959

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1182

300
-57

4

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Oresthaven Rest Home		d. STREET ADDRESS (If outside, give location) 3737 Highland	
Length of stay in lb 82 years		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Lillian Moore			4. DATE OF DEATH Month Day Year March 3, 1959			
--	--	--	---	--	--	--

5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1873	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
---------------	------------------------	---	--------------------------------	------------------------------------	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Aubrey Kansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	---	---	--

13a. FATHER'S NAME Alfred Collins	13b. MOTHER'S MAIDEN NAME Isabelle Sanders	14. NAME OF HUSBAND OR WIFE William H. Moore (deceased)
--------------------------------------	---	--

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 Lillian Blankenship	Address 3737 Highland
---	---------------------------------	--------------------------------------	--------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Meckel's diverticulitis with localized Peritonitis.		INTERVAL BETWEEN ONSET AND DEATH 9 days
DUE TO (b) Chronic Arteriosclerosis of the aorta with myocardial infarction		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
DUE TO (c) Chronic Arteriosclerosis of the aorta with myocardial infarction		

20a. ACCIDENT SUICIDE HOMICIDE Arteriosclerotic embolism	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Chronic Arteriosclerosis of the aorta with myocardial infarction
---	--

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 Death occurred at Nov 1944 7:25 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.	March 3 1959 and last saw her alive on March 2, 1959
---	--

22a. SIGNATURE Carl R. Ferris	(Degree or title) MD	22b. ADDRESS 535 Eagle Blvd Kansas City, Mo	22c. DATE SIGNED 3-4-59
----------------------------------	----------------------	---	----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE March 5, 1959	23c. NAME OF CEMETERY OR CREMATORY Aubrey Cemetery	23d. LOCATION (City, town, or county) (State) Aubrey Kansas
--	----------------------------	---	--

24. FUNERAL DIRECTOR Muehlebach	ADDRESS 6000 Troost	25. DATE RECD. BY LOCAL REG. 3.4.59	26. REGISTRAR'S SIGNATURE Reva Minshall
------------------------------------	------------------------	--	--

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Dr. Frank J. ...
Angela B. ...
VI.2 - 8227

7/19/20

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 R. E. Nichols

Licensed Embalmer No. 4997

P. O. Address K. P.

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.