

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010268

STATE FILE NUMBER

FILED MAR 19 1959

Registration District No.

156240

Primary Registration District No.

2001

Registrar's No.

132

1. PLACE OF DEATH a. COUNTY NEWTON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY NEWTON	
b. CITY OR TOWN RURAL		c. CITY OR TOWN RURAL	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION RT. 4, JOPLIN		d. STREET ADDRESS RT. 4, JOPLIN	
3. NAME OF DECEASED (Type or print) BESSIE LOUISE MOORE		4. DATE OF DEATH Month Day Year FEB. 27, 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 30, 1884
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) DESMOINES, IOWA
13a. FATHER'S NAME JOHN SPAULDING		13b. MOTHER'S MAIDEN NAME MARY GILLIAN	14. NAME OF HUSBAND OR WIFE MILES M. MOORE
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.	17. INFORMANT Address MILES M. MOORE, RT. 4, JOPLIN
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cholelithiasis DUE TO (b) Atherosclerosis DUE TO (c) _____ 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 2 days
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 a.m. p.m. Month, Day, Year			
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	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at St. Joseph's Hosp. 8:30 a.m. on the date stated above; and to the best of my knowledge from the causes stated.			
22a. SIGNATURE (Degree or title) A. L. Crawford M.D.		22b. ADDRESS Joplin Mo	22c. DATE SIGNED 3/4/59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 3-2-59	23c. NAME OF CEMETERY OR CREMATORY OSBORNE MEMORIAL CEM.	23d. LOCATION (City, town, or county) (State) JOPLIN, MISSOURI
24. FUNERAL DIRECTOR STEVE PARKER MORTUARY		25. DATE RECD. BY LOCAL REG. 3-9-1959	26. REGISTRAR'S SIGNATURE Dove Merriam

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

VS MAR 1 1960

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 *F. M. Jones*

Licensed Embalmer No. *2319*

P. O. Address *Jeff. Hill Me.*

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.