

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014991

FILED VS APR 19 1960

STATE FILE NUMBER

Registration District No. 132 Primary Registration District No. 3021 Registrar's No. 69

DED

1. PLACE OF DEATH a. COUNTY <u>GRUNDY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>GRUNDY</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>TRENTON</u>		Length of stay in 1b		c. CITY OR TOWN <u>SPICKARD</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>WRIGHT MEMORIAL ANNEX</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>PEARL</u> Last <u>MOORE</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>8</u> Year <u>1960</u>									
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-2-1880</u>		9. AGE (last birthday) <u>79</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <u>KENTUCKY</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>JAMES GROW</u>				13b. MOTHER'S MAIDEN NAME <u>ALICE RAY</u>				14. NAME OF HUSBAND OR WIFE <u>GENE MOORE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>499-16-5798 B</u>				17. INFORMANT Address <u>GLADYS STRAIN Spickard MO.</u>					
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>Arterio-Sclerotic Heart Disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>about 1 yr.</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
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 16.)					
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 <u>Feb. 18-1960</u> to <u>April 8-1960</u> and last saw her ^{her} him alive on <u>April 8-1960</u> Death occurred at <u>9:25 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>G. H. Cullers M.D.</u> (Degree or title)						22b. ADDRESS <u>Trenton, Mo.</u>				22c. DATE SIGNED <u>April 10/1960</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>4-10-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY</u>				23d. LOCATION (City, town, or county) <u>GRUNDY CO. MO.</u>					
24. FUNERAL DIRECTOR <u>SCHOOLER FUNERAL HOME Spickard MO.</u>				ADDRESS				25. DATE RECD. BY LOCAL REG. <u>4/15/60</u>		26. REGISTRAR'S SIGNATURE <u>Jene Fair</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Ross Wise

Licensed Embalmer No. 3771

P. O. Address Spickard 97

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.