

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048779

FILED VS. JAN 24 1961

149

Primary Registration District No. 1002

Registrar's No.

6583

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Caldwell</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>25 days</b>		c. CITY OR TOWN <b>Hamilton</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>-</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Infant</b> Middle <b>-</b> Last <b>Mogg</b>				4. DATE OF DEATH Month <b>12-29-</b> Day <b>1960</b> Year					
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-4-1960</b>	9. AGE (last birthday) <b>25</b>	IF UNDER 1 YEAR Months <b>25</b> Days	IF UNDER 24 HR Hours <b>25</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>infant</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Kansas City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		
13a. FATHER'S NAME <b>James C. Mogg</b>			13b. MOTHER'S MAIDEN NAME <b>Marlene Hales</b>			14. NAME OF HUSBAND OR WIFE <b>none</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>James Mogg</b> Address <b>Hamilton, Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <b>cardiac failure</b>									
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.									
DUE TO (b) <b>ruptured membrane spinal bifida</b>									
DUE TO (c) <b>hydrocephalus</b>									
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 type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)						
20c. TIME OF INJURY Hour <b>11:30A.</b> Month, Day, Year <b>Dec. 4, 60</b>		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 <b>12-29-60</b>		COUNTY <b>Hamilton</b> STATE <b>MO</b>	
21. I attended the deceased from <b>11:30A.</b> to <b>12-29-60</b> and last saw her/him alive on <b>12-29-60</b> . Death occurred at <b>11:30A.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>John T. Skinner MD</i> (Degree or title)				22b. ADDRESS <b>1102 Grand</b>			22c. DATE SIGNED <b>12-29-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>12-29-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Highland</b>		23d. LOCATION (City, town, or county) (State) <b>Hamilton, Mo.</b>				
24. FUNERAL DIRECTOR <b>Bram Mortuary</b> ADDRESS <b>Hamilton, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>12-29-60</b>		26. REGISTRAR'S SIGNATURE <i>H-L Dwyer</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF  
John T. Skinner

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 *John R. Bidman* .....

Licensed Embalmer No. *4531* .....  
P. O. Address *Kansas City* .....

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.