

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-024884

STATE FILE NUMBER

Registration District No. 132 Primary Registration District No. 3021 Registrar's No. 131

AMENDED

FILED AUG 14 1961

1. PLACE OF DEATH a. COUNTY <u>GRUNDY</u>		2. USUAL RESIDENCE (Where deceased lived. 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>		c. CITY OR TOWN <u>TRENTON</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>1513 Chestnut</u>		d. STREET ADDRESS (If outside, give location) <u>1513 Chestnut</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>EVA</u> Middle <u>De</u> Last <u>MOSS</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>6</u> Year <u>1961</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</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>July 23 1882</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Household</u>	11. BIRTHPLACE (City and state or country) <u>Iberia Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>HENRY SLODEN</u>	13b. MOTHER'S MAIDEN NAME <u>NANCY WACHNACH</u>	14. NAME OF HUSBAND OR WIFE <u>James DeMoss (deceased)</u>
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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>NONE</u>	17. INFORMANT <u>FRED DeMoss</u> Address <u>Poola Kans</u>
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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>Cardio - Vascular - Renal Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 years</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 type="checkbox"/> No <input type="checkbox"/> Unknown
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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 18.)
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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 checked="" 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
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21. I attended the deceased from <u>August 1957</u> to <u>August 1961</u> and last saw her/him alive on <u>July 1st 1961</u> Death occurred at <u>4:20 A</u> m on the date stated above and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Oliver F. Duffly MD.</u> (Degree or title)	22b. ADDRESS <u>Trenton Mo</u> DATE SIGNED <u>Aug 21 1961</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Aug 8, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <u>VERSAILLES Mo.</u>
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24. FUNERAL DIRECTOR <u>Doyle Blackman</u> ADDRESS <u>Trenton Mo</u>	25. DATE REC'D. BY LOCAL REG. <u>8-8-61</u>	26. REGISTRAR'S SIGNATURE <u>Frene Fair</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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 Claude H. Curdson

Licensed Embalmer No. 4986

P. O. Address Henry M.

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.