

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-005556

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 50 Primary Registration District No. 5179 Registrar's No. 10
FILED FEB 18 1963

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
 AMENDED

VS 300
 Rev. 4/59
 10150
 8150
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 4 1
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 12 90-0
 13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Camden</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Camden</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Camden Jackson Township</u>		Length of stay in 1b <u>54 yrs</u>	c. CITY OR TOWN <u>Montreal</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in Hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS <u>Montreal</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Kate Moulder Crall</u>			4. DATE OF DEATH Month Day Year <u>Feb 9th 1963</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>Aug 10-1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School Teacher</u>	9. AGE (last birthday) <u>88</u>
11. BIRTHPLACE (City and state or country) <u>Camden County Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Joseph C. Moulder</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Cyrus</u>	
14. NAME OF HUSBAND OR WIFE <u>James Crall</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>no</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Ethel Huston Montreal Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular-Renal disease with</u> DUE TO (b) <u>Myocardial Degeneration</u> DUE TO (c) <u>Serile Arterio-sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u>			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 18.)	
20c. TIME OF INJURY Hour, a.m. or 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>May 1957</u> to <u>Feb 9 63</u> and last saw her/him alive on <u>Feb 4 1963</u> Death occurred at <u>2:15 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Thos A. Wayland Md</u>		22b. ADDRESS <u>Camden, Missouri</u>	22c. DATE SIGNED <u>2-9-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 11th 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Roach Cemetery</u>	23d. LOCATION (City, town, or county) <u>Roach Mo</u>
24. FUNERAL DIRECTOR <u>Robert H. Reed</u>		25. DATE RECD. BY LOCAL REG. <u>Feb. 9-1963</u>	26. REGISTRAR'S SIGNATURE <u>Zilpha J. Inaw</u>

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 Robert H Reed

Licensed Embalmer No. 3745

P. O. Address Camdenton Mo

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.