

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-006839

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 920 STATE FILE NUMBER

**FILED FEB 26 1963**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

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> b. COUNTY <b>Jackson</b>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>50yrs</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3001 Woodland</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <b>2437 Olive</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Genie Moore</b>			4. DATE OF DEATH Month <b>2</b> Day <b>9</b> Year <b>63</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-4-1882</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>80</b> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR
11. BIRTHPLACE (City and state or country) <b>Louisiana, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Charlie Smith</b>		13b. MOTHER'S MAIDEN NAME <b>Susie Robinson</b>	
14. NAME OF HUSBAND OR WIFE <b>Isaac W. Moore</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.		17. INFORMANT Address <b>Beatrice Moore 2427 Olive</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertension</b>			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 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. 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 <b>2 Oct 62</b> to <b>Feb 9, 63</b> and last saw <b>her</b> alive on <b>8 Feb 63</b> Death occurred at <b>3:30 AM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>John H. Wells MD</b>		22b. ADDRESS <b>3718 Prospect</b>	22c. DATE SIGNED <b>9 Feb 63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2-13-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Highland</b>	23d. LOCATION (City, town, or county) <b>Kansas City</b> (State) <b>MO.</b>
24. FUNERAL DIRECTOR <b>Watkins Bros. Funeral Home 18th Benton</b>		25. DATE RECD. BY LOCAL REG. <b>2-11-63</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF MASSACHUSETTS

DEPARTMENT OF HEALTH

REGISTRATION BOARD

EMBALMERS

Form

1-1-68

MASSACHUSETTS

DEPARTMENT OF HEALTH

REGISTRATION BOARD

EMBALMERS

**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 *James A. Watkins*

Licensed Embalmer No. 4500

P. O. Address *1 Pine Street*

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.