

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-011801

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1545

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 21 1963		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Jackson</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		a. STATE <b>Mo.</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		Length of stay in 1b <b>32 Years</b>		b. COUNTY <b>Jackson</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kansas City</b>	
				d. STREET ADDRESS (If outside, give location) <b>2615 Denver</b>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. AGE (last birthday)	
First Middle Last <b>MARGARET ADAH MOFFATT</b>		Month Day Year <b>March 7 1963</b>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</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>8-28-1874</b>	9. AGE (last birthday) <b>88</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Mears, Michigan</b>	
13a. FATHER'S NAME <b>John M. Roush</b>		13b. MOTHER'S MAIDEN NAME <b>Emmaline Knapp</b>		14. NAME OF HUSBAND OR WIFE <b>Benjamin Moffatt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Charles Edwards 2615 Denver</b>	
18. CAUSE OF DEATH (Enter only one cause per line)		PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH	
		IMMEDIATE CAUSE (a) <b>Anterior cardiac infarction, acute</b>		<b>3 days</b>	
		DUE TO (b) <b>Left bundle branch heart block</b>		<b>25 years</b>	
		DUE TO (c) <b>Arteriosclerotic heart disease</b>		<b>15 years</b>	
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cardiac hypertrophy, moderate.</b>		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 checked="" 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 Month, Day, Year a.m. p.m.					
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>1-3-46</u> to <u>3-7-63</u> and last saw her/him alive on <u>3-7-63</u> Death occurred at <u>6:35 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>James A. Chambers M.D.</b>		22b. ADDRESS <b>412 Plaza Pkwy. Bldg. Kansas City 12, Mo.</b>		22c. DATE SIGNED <b>3-8-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3-11-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Pittsburg, Kansas</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Muehlebach 6800 Troost</b>		25. DATE RECD. BY LOCAL REG. <b>3 8-63</b>		26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF James A. Chambers Medical Certification

USE BLACK INK OR TYPEWRITER RIBBON

James A. Chamber, Jr.  
4620 J.C. Nichols  
WE-1-1850

Between 1.00 + 5.00  
suggested best time 11.00 P.M.

**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 G. Landes

Licensed Embalmer No. 5103

P. O. Address K.C. 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.

OK

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