

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-011804

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1690

STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

FILED APR 1 1963

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Iowa b. COUNTY Linn	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		Length of stay in 1b 8 Months	c. CITY OR TOWN Cedar Rapids
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION New Hope Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 600 1/2 B. Ave. N. E.
3. NAME OF DECEASED (Type or print) First RUBY Middle PAULINE Last MOORE		4. DATE OF DEATH Month March Day 13 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-12-1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 70
13a. FATHER'S NAME Alonzo Morehead		13b. MOTHER'S MAIDEN NAME Amanda Holiday	11. BIRTHPLACE (City and state or country) Cedar Rapids, Iowa
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	12. CITIZEN OF WHAT COUNTRY U. S. A.
17. INFORMANT Ray Moore		Address Cedar Rapids, Iowa	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Pulmonary Congestion DUE TO (c) Bronchogenic Carcinoma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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 _____ 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 Cedar Rapids	
20g. COUNTY Linn		20h. STATE Iowa	
21. I attended the deceased from 1-1-63 to 3-13-63 and last saw her ^{him} alive on 3-11-63 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Olto H. Thiel M.D. (Degree or title)		22b. ADDRESS 4301 Main St. KCMo	
22c. DATE SIGNED 3-14-63		22d. LOCATION (City, town, or county) (State) Kansas City, Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 3-15-63	
23c. NAME OF CEMETERY OR CREMATORY Elmwood Crematory		23d. LOCATION (City, town, or county) (State) Kansas City, Mo.	
24. FUNERAL DIRECTOR Freeman Mortuary		25. DATE RECD. BY LOCAL REG. 3-15-63	
ADDRESS Kansas City, Mo.		26. REGISTRAR'S SIGNATURE Ruth Long	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION

Otto H. Thiel

USE BLACK INK OR TYPEWRITER RIBBON

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 Clayton Barnes

Licensed Embalmer No. 4793

P. O. Address K. Q. 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.