

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

35648

Do not use this space.

## 1. PLACE OF DEATH

(a) County Calloway Registration District No. 104  
(b) Township 1 Primary Registration District No. 3008 Registered No. 287  
(c) City Fulton (d) Street No. \_\_\_\_\_ St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Ollie D Moore head

(a) Residence, No. Lancaster Mo St.  State Hospital No 1  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
55 ? ?

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

13. NAME William Moon head

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Linn

15. MAIDEN NAME Moon

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT E. C. Cox  
(ADDRESS) Lancaster Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE Lancaster, Mo DATE Oct 15 1939

19. FUNERAL DIRECTOR (NAME) Les G. Wallace  
(ADDRESS) Fulton Missouri

20. FILED 10/15 1939 R. N. Crewe  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-15 1939

22. I HEREBY CERTIFY, That I attended deceased from Oct 11 1939, to Oct 15 1939

I last saw him alive on Oct 14 1939. Death is said to have occurred on the date stated above, at 7:45 A. M.

The principal cause of death and related causes of importance were as follows:

Lobar. Pneumonia

Date of onset

Other contributory causes of importance:

Influenza

Name of operation none Date of \_\_\_\_\_

What test confirmed diagnosis? Ch. Hist. Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) Forest Thomas M. D.

(Address) State Hospital No 1

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *Harold J. Christey*  
Licensed Embalmer No. *4002*  
P. O. Address *Oulton, 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 this body is not embalmed, above space should be left blank.**