

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

DEC 21 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

39371

State File No. _____

Registration District No. 4124

Primary Registration District No. 41-11

Registrar's No. 17

1. PLACE OF DEATH:

(a) County Clinton

(b) City or town Lathrop

(c) Name of hospital or institution: ✓

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME James Moore b50

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married divorced married

6. (b) Name of husband or wife Rodie Dunwell Moore 6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased may 15 1879 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

60 5 22 hr. min.

9. Birthplace Clinton Co. Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Frank Moore

13. Birthplace Kentucky (City, town, or county) (State or foreign country)

14. Maiden name Mary Walton

15. Birthplace Penn. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature William Moore

(b) Address Hick, Mo.

17. (a) Burial (b) Date thereof Nov 8-1939 (Barial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Antisch, Hick, Mo.

18. (a) Signature of funeral director Leonard Fry

(b) Address Keans, Mo.

19. (a) Nov. 7-39 (b) L. B. Emerson (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clinton

(c) City or town Lathrop Mo (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 6th year 1939 hour 11 minute 50 a.m.

21. I hereby certify that I attended the deceased from Nov-2 to Nov-6-39 that I last saw him alive on Nov 6 and that death occurred on the date and hour stated above.

Immediate cause of death Impetive heart failure

Due to chronic nephritis

Due to _____

Other conditions (Include pregnancy within 3 months of death) 181

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

181 While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature L. A. Longfield (M. D. or other) _____

Address Lathrop, Mo Date signed 11/7/39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

RECEIVED

District Health Officer No. 44

District No.

1239-1770

DEC 18-1939----

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.....

Leonard Fry

Licensed Embalmer No.....

1677

P. O. Address.....

Kearney

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.