

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 332

157  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: **Buchanan**

(a) County **Buchanan**

(b) City or town **St Joseph**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **St Joseph's Hospital**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 YEAR**  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **ROSE E. MOORE (wid)**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **FEMALE**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **William Moore**

6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased: **Oct. 3rd 1856**  
(Month) (Day) (Year)

8. AGE: Years **83** Months **5** Days **21**  
If less than one day hr. min.

9. Birthplace **UNKNOWN Conn.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Home**

MOTHER FATHER { 12. Name **PATRICK HORAN**

13. Birthplace **UNKNOWN IRELAND**  
(City, town, or county) (State or foreign country)

14. Maiden name **KATHERINE McCOY**

15. Birthplace **UNKNOWN IRELAND**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. J.C. Nesbitt**

(b) Address **2908 Sylvania St. Joseph Mo**

17. (a) **REMOVAL** (b) Date thereof **MAR. 24, 40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Atchison, KANSAS**

18. (a) Signature of funeral director **FLEEMAN & SON, INC.**

(b) Address **1946 Calhoun St. Joseph Mo**

19. (a) **March 25, 1940** (b) **J.D. Neatle**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Buchanan**

(c) City or town **St Joseph**  
(If outside city or town limits, write "RURAL")

(d) Street No. **2908 Sylvania**  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAR.** day **24**  
year **1940** hour **1** minute **55 P.M.**

21. I hereby certify that I attended the deceased from **9/24**, 19**35**, to **3/24**, 19**40**  
that I last saw her, alive on **3/24**, 19**40**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**

Due to **arterio Sclerosis + Hyper Tension**

Other conditions **Serility**

Major findings: Of operations **none**

Of autopsy **none**

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

(a) Accident, suicide, or homicide (specify) **none**

(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? **no**

**85** While at work? **no** (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **J.H. Thompson** (M. D. \_\_\_\_\_)

Address **825 Charles St. Joseph Mo** Date signed **3/25/40**

Duration **6 days**

**6 yrs**

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged etiologically.

**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 C. L. Swan

Licensed Embalmer No. 4082

P. O. Address St Joseph

**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.**