

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.

FILED APR 23 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11477

Registration District No. 451 Primary Registration District No. 5616 Registrar's No.

1. PLACE OF DEATH:
(a) County LACLEDE
(b) City or town ELDRIDGE TWP.
(c) Name of hospital or institution: IRA, MO.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7
In this community 73 YRS
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Laclede
(c) City or town Rural Ea. Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME ARYA LENNE MOORE
3. (b) If veteran, name war. 3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month MAR, day 28, year 1940, hour 2, minute 30 A.M.
21. I hereby certify that I attended the deceased from Nov. 1939, 19 , to Jan. 15, 1940.
that I last saw her alive on Jan 15, 1940.
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife FM. MOORE 6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased JUNE 30 - 1965
(Month) (Day) (Year)

Immediate cause of death Pulmonary tuberculosis Duration 9 yrs

8. AGE: Years 73 Months 9 Days 8 If less than one day hr. min.

Due to Fractured
Due to 72

9. Birthplace CAMDEN CO. MO
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations none
Of autopsy none

10. Usual occupation HOUSE WIFE

11. Industry or business
12. Name JOSEPH PHILLIP'S
13. Birthplace US
14. Maiden name LOUISE GREEN
15. Birthplace US
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Willis Moore
(b) Address Eldredge Mo.

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?

17. (a) BURIAL (b) Date thereof IRA MO 3 29 40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation

While at work? (Specify type of place) (e) Means of injury
23. Signature [Signature] (M. D. or other) MD
Address Lebanon, Mo. Date signed 3/28/40

18. (a) Signature of funeral director Palmer's
(b) Address Lebanon Mo. 404
19. (a) April (b) Nara Cole
(Date received local registrar) (Registrar's signature)

RECEIVED
District Health Officer No. 7,
District File Number 4-46-569
Date Filed 4-8-40

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 W. A. Palmer
Licensed Embalmer No. 1161
P. O. Address Delaware 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.