

Registration District No. 604

Primary Registration District No. 4360

Registrar's No.

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

1. PLACE OF DEATH:

(a) County. New Madrid

(b) City or town. Paint Pleasant, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: No

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

(d) Length of stay: In hospital or institution. No (Specify whether)

In this community About 6 years
years, months or days) 6

8. (a) PRINT FULL NAME JAMES MOORE

8. (b) If veteran name war No

8. (c) Social Security No. No

4. Sex. M

5. Color or race. Colored

6. (a) Single, widowed, married, divorced. MARRIED

6. (b) Name of husband or wife. MATTIE MOORE

6. (c) Age of husband or wife if alive. 30 years

7. Birth date of deceased. Jan 1900
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>About 39</u>			hr. min.

9. Birthplace. IN GEORGIA No. 1
(City, town, or county) (State or foreign country)

10. Usual occupation. FARMING (DAY WORK)

11. Industry or business. No

MOTHER FATHER

12. Name. JIM MOORE

13. Birthplace. unk. 9
(City, town, or county) (State or foreign country)

14. Maiden name. unk.

15. Birthplace. unk. 9
(City, town, or county) (State or foreign country)

16. (a) Informant. Mattie Moore

(b) Address. Paint Pleasant, Mo

17. (a) Burial (b) Date thereof. Feb. 25, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Paint Pleasant, Mo

18. (a) Signature of funeral director. Richards and Co

(b) Address. New Madrid, Mo

19. (a) 3/4/1940 (b) Wm O'Bannon
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. Missouri (b) County. New Madrid

(c) City or town. Paint Pleasant, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. Paint Pleasant
(If rural, give location)

(e) If foreign born, how long in U. S. A.? No years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 24
year 1940 hour 5:00 minute AM

21. I hereby certify that I attended the deceased from Feb 18th
1940 to Feb 23rd, 1940
that I last saw him alive on Feb 23rd, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death. Crowned
Coronary Thrombosis

Due to _____

Due to _____

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

Major findings: No operation

Of operations _____

Of autopsy. no 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? _____

533 (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature. R Lee McDaniel (M. D. or other) _____
Address. Paint Pleasant Date signed. 2/24/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

55A

DA
PA
RECEIVED

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 Leo Hedgcock, Registered Apprentice No. _____ working under my personal supervision.

Signed Leo Hedgcock
Licensed Embalmer No. 3803
P. O. Address New Madrid, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11811

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 604

Primary Registration District No. 4360

Registrar's No.

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

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Point Pleasant
(If outside city or town limits, write "RURAL" and name of township)
(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

3. (b) If veteran name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years abt 39 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____ (City, town, or county) _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 Feb day 24 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral aneurysm caused from tumor on brain

Due to Don't know as to malignancy

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

Major findings: Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? _____

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

23. Signature R. Lee Williams (M. D. or other) _____

Address Point Pleasant Date signed _____

SUPPLEMENTAL

11811 (1940)