

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

12081

FILED APR 18 1940

Registration District No. _____

Primary Registration District No. 4424

State File No. _____

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Polk
 (b) City or town Humansville
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Geo. Demuth Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution night 1 day
 (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Polk
 (c) City or town Humansville - 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.

3. (a) PRINT FULL NAME Rolland Moore
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Mar day 30
 year 1940 hour 6 minute 20 a. M.

4. Sex male 5. Color or race white
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Muriel Moore
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Sept. 10, 1897
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Mar 29, 1940, to _____, 1940;
 that I last saw him alive on Mar 29, 1940,
 and that death occurred on the date and hour stated above.

8. AGE: Years 42 Months 7 Days 20
 If less than one day _____ hr. _____ min.

Immediate cause of death Fracture of base of skull
 Due to Automobile
 Due to _____

9. Birthplace Weaubleau Mo
 (City, town, or county) (State or foreign country)
 10. Usual occupation Wagon Salesman

Other conditions (Include pregnancy within 3 months of death)
 Major findings: Of operations _____
 Of autopsy _____

MOTHER FATHER
 11. Industry or business _____
 12. Name Refush Moore
 13. Birthplace Mo
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary Boone
 15. Birthplace Calif
 (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 Muriel Moore
 (b) Address Weaubleau Mo
 17. (a) Burial (b) Date thereof 3/31/40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Butcher Cen
 18. (a) Signature of funeral director J. L. Luster
 (b) Address Wheatland Mo
 19. (a) April 15, 1940 (b) Ora M. Rich
 (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) accident
 (b) Date of occurrence Mar. 28, 1940
 (c) Where did injury occur? Near Humansville
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

 _____ (Specify type of place) _____
 While at work? Yes (e) Means of injury _____
 23. Signature [Signature] (M. D. or other) _____
 Address [Address] Date signed 4/24/40

210 m
9 87

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 *J.P. Lucky*.....

Licensed Embalmer No. *2982*.....

P. O. Address *Whitland*.....

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. 12084

Registration District No. 703

Primary Registration District No. 4424

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Polk
 (b) City or town Hannanville
(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 Rolland Moore

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

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

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

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

8. AGE: Years 42 Months 7 Days 20 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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 Mar day 30
 year 1940 hour _____ minute _____ M.

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

Immediate cause of death fracture of base of skull

Due to Automobile

Due to collision with stone pole

Other conditions: 210 m
(Include pregnancy within 3 months of death)

Major findings: Auto fracture

Of operations: none

Of autopsy: none

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) Accident

(b) Date of occurrence March 29 - 1940

(c) Where did injury occur? on highway 57 West of Hannanville
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

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

23. Signature E. B. Hannan (M. D. or other) _____

Address Bellevue Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

1940

S-72084