

Registration District No. 773Primary Registration District No. 6018ARegistrar's No. 58

## 1. PLACE OF DEATH:

(a) County St. Francois  
 (b) City or town Near Farmington  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: State Hospital No. 4  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 19 yr. 0 mo. 2 day  
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Barbara C. Moore 600

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
 6. (b) Name of husband or wife Single 6. (c) Age of husband or wife If alive None years  
 7. Birth date of deceased 1866  
 (Month) (Day) (Year)

8. AGE: Years 74 Months Un. Days Un. If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Bollinger Co. Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 { 12. Name Unknown 9  
 { 13. Birthplace " " 1  
 (City, town, or county) (State or foreign country)  
 { 14. Maiden name " " 9  
 { 15. Birthplace " " 9  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Records of State Hospt. #1  
(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof March 14, 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Germania Cemetery

18. (a) Signature of funeral director Benjamin Ford Co  
 (b) Address 313 Berham St. Farmington, Mo.

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

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois  
 (c) City or town Ronne Terre  
 (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 March day 12  
year 1940 hour 6 minute 20 P. M.

21. I hereby certify that I attended the deceased from 3-15, 1937 to 3-12, 1940;  
 that I last saw her alive on 3-12, 1940;  
 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Terminal bronchopneumonia</u>	<u>3-10-40</u>
Due to <u>Cerebral hemorrhage</u>	<u>3-9-40</u>
Due to <u>Generalized arteriosclerosis</u>	<u>12 yrs +</u>

Other conditions (Include pregnancy within 3 months of death) 87KMajor findings:  
Of operations \_\_\_\_\_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) \_\_\_\_\_  
 (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  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Paul J. Schradn (M. D. or other) MD  
 Address Farmington, Mo. Date signed 3-16-40

APR 23 1940

---

---

**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. J. Claywell*

Licensed Embalmer No. *3706*

P. O. Address *Bonne Terre 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. 12264

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 773

Primary Registration District No. 6018A

Registrar's No.

1. PLACE OF DEATH

(a) County St. Francois  
(b) City or town St. Francois, Mo.  
(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 Barbara C. Moore

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced 8

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years 74 Months - Days - If less than one day \_\_\_\_\_ 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 \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Mar 15-40 (b) T. B. Robinson  
(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 17  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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? \_\_\_\_\_

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

23. Signature Paul J. Straggle D. or other) \_\_\_\_\_

Address Farmington \_\_\_\_\_

SUPPLEMENTAL

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1940  
S-12264