

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.

MAY 13 1940
Registration District No. 318

Primary Registration District No. 2001

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Baptist Hospital
(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 2 0 0

3. (a) PRINT FULL NAME Inf. son of Mr + Mrs Leonard Moore
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 8 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 1 hr. min.

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

10. Usual occupation Infant

11. Industry or business _____
12. Name Leonard Moore
18. Birthplace Ash Grove Mo
(City, town, or county) (State or foreign country)
14. Maiden name Janice Young
15. Birthplace Jackson Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Leonard Moore
(b) Address Yalloway, Mo

17. (a) Burial (b) Date thereof 4-10-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ash Grove Mo

18. (a) Signature of funeral director Alma Lehman
(b) Address Springfield Mo

19. (a) 4/16/40 (b) Chas. R. George
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Yalloway, 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.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 9,
year 1940 hour 3 minute P. M.
21. I hereby certify that I attended the deceased from 4/8/1940, to 4/9/1940,
that I last saw him alive on 4/9/1940
and that death occurred on the date and hour stated above.

Immediate cause of death Spontaneous Collapse Lung
Due to Primaturity
Due to Mucous plug in bronchus
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____
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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? _____
(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature Herwood B. Hall (M. D. or other) _____
Address 500 Hallway Bldg Date signed 4/10/40

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

Springfield Mo

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 Harlow Knabb

Licensed Embalmer No. 4065

P. O. Address Springfield 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.