DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22368

Registration District No. 605

Primary Registration District No. 4359

Registrar's No.

1. PLACE OF DEATH:

(a) County New Madrid Comm

(b) City or town Catron

(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid

(c) City or town Catron

(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 Bobbie Gene Moore

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex F

5. Color or race Negro

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

6. (b) Name of husband or wife —

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

7. Birth date of deceased Mar (Month) 24 (Day), 1940 (Year)

8. AGE: Years | Months 3 | Days 8 | If less than one day hr. min.

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

10. Usual occupation nil

11. Industry or business

FATHER
12. Name Robert Moore
13. Birthplace Mark Tree (City, town, or county) Ark (State or foreign country)

MOTHER
14. Maiden name Anna May Ratcle
15. Birthplace — (City, town, or county) Ark (State or foreign country)

16. (a) Informant's own signature Robert Moore

(b) Address Catron

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2-40 (Month) (Day) (Year)

(c) Place: burial or cremation Catron

18. (a) Signature of funeral director 534

(b) Address

19. (a) 7-2-40 (Date received local registrar) (b) Dr. Geo W Husted (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2 year 1940 hour 2:00 minute 9 M.

21. I hereby certify that I attended the deceased from I did not see baby 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Possible smothered under bed clothing

Due to (History from father)

Due to

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) Possibly smothered

(b) Date of occurrence 7-2-40

(c) Where did injury occur? Baby's home (City or town) (County) Catron, Mo (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 Geo W Husted (M. D. or other)

Address Parma, Mo Date signed 7/2/40

(Licensed Embalmer's Statement on Reverse Side) Local Registrar

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.

WHITE PAPER—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1 X10511

RECEIVED
District Health Officer No. 2
District File Number 740 - 1212
Date Filed 7/10/40

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.....

Licensed Embalmer No.....

P. O. Address.....

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.