

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Sullivan, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
At Home
(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 _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Robert M. Moore

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary F. Moore 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov. 24th, 1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 II 24 _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business _____

12. Name Joe Moore

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

14. Maiden name Sarah Terrell

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

16. (a) Informant G.P. Moore
(b) Address 4054 Russell, St. Louis, Mo.

17. (a) Burial (b) Date thereof Nov. 18, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sullivan, Mo.

18. (a) Signature of funeral director J. Williams

(b) Address Sullivan, Missouri

19. (a) 11-18-1940 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

(c) City or town Sullivan,
(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 Nov. day 16th.
year 1940, hour II minute _____ A. M.

21. I hereby certify that I attended the deceased from Nov 9, 1940, to Nov 16, 1940, that I last saw him alive on Nov 16, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Sub acute prostatic hypertrophy Duration 10 years

Due to _____

Due to _____

Other conditions Renal hypertension LWK
(Include pregnancy within 3 months of death)

Major findings: None PHYSICIAN _____

Of operations _____ Underline the cause to which death should be charged statistically.
Of autopsy None

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? _____

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

23. Signature D. L. Barnes D. or other _____

Address Sullivan Mo Date signed Nov 18 1940

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

066

DEC 11 1940
295

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. ~~427~~

working under my personal supervision.

Signed

J. T. Williams

Licensed Embalmer No. 427

P. O. Address, *Sullivan*

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.