

No. 2  
4-13-40  
-17-39  
X22

**FILED** SEP 10 1941 85

Primary Registration District No. 1001

Registrar's No. 800

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St. Joseph's Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day  
(Specify whether years, months or days)

In this community 60 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No. 2724 Locust St.  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

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

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased October 23, 1859  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>9</u>	<u>14</u>	hr. _____ min.

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

10. Usual occupation Retired painter

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

12. Name Dr. T.M. Moore

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

14. Maiden name Frances Parr

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

16. (a) Informant Chas. P. Moore

(b) Address 2724 Locust St. St. Joseph, Mo.

17. (a) Burial (b) Date thereof Aug. 9, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Arman W. [Signature]

(b) Address 1802 Union Str. St. Joseph, Mo.

19. (a) 8/8/1941 (b) [Signature]  
(Date received local registrar) (Registrator's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 7th  
year 1941 hour 5 minute 15 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 1941, to 8/7, 1941  
that I last saw him alive on Aug 7, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Subtotal obstruction Duration 3 days

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

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

Other conditions Senility  
(Include pregnancy within 3 months of death)

Major findings: None  
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? \_\_\_\_\_

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

23. Signature M. H. Tally (M. D. or other) MD  
Address St. Joseph, Mo. Date signed 8-8-41

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

**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 *Albert C. Harrington*

Licensed Embalmer No. 3258

P. O. Address St. Joseph, 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, fact should be so stated above.**