

No. 2
1-4-41
-17-39

FILED DEC 10 1941

Registration District No. 175

Primary Registration District No. 6161

Registrar's No. 331

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Rural - Badger Twp
(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: 5 years in hospital or institution _____
(Specify whether years, months or days)

In this community 5 years _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Vernon 108

(c) City or town Rural - Badger Twp 3
(If outside city or town limits, write "RURAL")

(d) Street No. R. T. D # 2, Nevada, Mo.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 10

3. (a) PRINT FULL NAME James A. Moore

3. (b) If veteran, name war no.

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 21
year 1941 hour Doit minute _____ M.

21. I hereby certify that I attended the deceased from Doit not
attended him at any time 19____ to _____ 19____
that I last saw him alive Doit Doit 19____
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased Nov. 11 1857
(Month) (Day) (Year)

Immediate cause of death _____ Duration _____

Found dead in his room
probably had heart disease
Due to as he was 84 year of age

Due to _____

8. AGE: Years Months Days If less than one day

84 0 10 _____ hr. _____ min.

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

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

10. Usual occupation Farmer - Retired

Major findings:
Of operations _____

Of autopsy _____

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

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown

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

14. Maiden name Unknown

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

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? _____

16. (a) Informant Miss Phenia Floyd

(b) Address Rt # 2, Nevada, Mo.

17. (a) Burial (b) Date thereof 11-24-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Deepwood Cemetery

18. (a) Signature of funeral director Hays Funeral Service

(b) Address Nevada, Mo.

19. (a) 11-24-41 (b) Allen V. Hays
(Date received local registrar) (Registrar's signature)

23. Signature A. Boyd, M.D. (M. D. or other) _____

Address _____ Date signed _____

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

RECEIVED

District Health Officer No. 7,

District File Number 12-41-1993

Date Filed 12-8-41

RECEIVED

RECEIVED

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 Allen V. Hoyle

Licensed Embalmer No. 1968

P. O. Address Nevada

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.

STANDARD CERTIFICATE OF DEATH

State File No. 39709

Registration District No. 875 Primary Registration District No. 616 Registrar's No. _____

1. PLACE OF DEATH

(a) County Lincoln

(b) City or town Rural
(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 James A. Moore

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

4. Sex M. 5. Color of race W.

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 Nov. 11, 1904
(Month) (Day) (Year)

8. AGE: Years 84 Months 0 Days 0 (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry of business _____

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) _____ (b) _____
(Data 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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. Day 11 year 1988 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 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 Heart disease of old age

Due to had seen him as a patient I don't know

Other conditions what type of heart

Major findings: had. There was no autopsy

Of operations _____

Of autopsy Dr. J. M. D.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (Specify) _____

(b) Date of occurrence 2000

(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. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

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

