

APR 8 1943
Registration District No. 210

Primary Registration District No. 5771

State File No. _____
Registrar's No. 110

1. PLACE OF DEATH:

(a) County Mercer
(b) City or town Rural, Marian Township.
(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 77 years (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Mercer
(c) City or town Rural near Mercer Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month march day 18
year 1943 hour 9 minute 30 A. M.
21. I hereby certify that I attended the deceased from march 16
3d 1943 to march 18 1943
that I last saw her alive on march 16 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Duration _____

Due to age
Due to _____

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

Major findings: Of operations _____
Of autopsy no

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?
Co.
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature J. M. Perry M.D. (M.D. or other)
Address Linerville Mo Date signed 3/19/43

3. (a) PRINT FULL NAME Rosa Belle Moore

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

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

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

7. Birth date of deceased June 7, 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 9 10 _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Marian Anderson

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

14. Maiden name Sarah Stuttilville

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

16. (a) Informant Dorothy M. Moore

(b) Address Linerville Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 20/43
(Month) (Day) (Year)

(c) Place: burial or cremation Moore Cemetery, Mercer Co.

18. (a) Signature of funeral director D. O. Greenlee

(b) Address Linerville Iowa

19. (a) 3-21-43 (Date received local registrar) (b) Jessie Alley (Registrar's signature)

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

MOTHER FATHER

1117

FEB 16 1958

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 *Amos L. Greuler*

Licensed Embalmer No. *3967*

P. O. Address. *Mercer 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10870
Registrar's No. 110

Registration District No. 210

Primary Registration District No. 5771

1. PLACE OF DEATH:

(a) County Mercer
(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)

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 _____

3. (a) PRINT FULL NAME Rosa Belle Moore

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased June 7 1864
(Month) (Day) (Year)

8. AGE: Years 47 Months 9 Days _____ If less than one day _____ min.

9. Birthplace Iowa
(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) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June 18
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death pneumonia; labor - double Duration 6 days

Due to age + general anemia

Due to _____

Other conditions (Include pregnancy within 3 months of death) 101

Major findings: Of operations _____

Of autopsy _____

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) (c) Means of injury _____

23. Signature JM Perty MD (Name of physician)
Address Chickellon 410 Date signed _____

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

SUPPLEMENTARY

S-10870