

FILED AUG 17 1943  
149

State File No. \_\_\_\_\_  
Registrar's No. 2390

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:  
General Hospital #2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7/7-7/31/43  
(Specify whether

In this community 27 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 815 E. 48th St.  
(If rural, give location)

(e) Citizen of foreign country? No (Yes  No )  
If yes, name country \_\_\_\_\_

3. (a) ~~PRINT~~ FULL NAME: HOMER J. MOORE

3. (b) If veteran, name war None

3. (c) Social Security No. # Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31 year 1943 hour 1:00 minute A M.

4. Sex Male 5. Color or race Negro

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

6. (b) Name of husband or wife: Ethel Lee Moore

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

7. Birth date of deceased: March 12 1896  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 7 1943 to July 31 1943 that I last saw him alive on July 31 1943 and that death occurred on the date and hour stated above.

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

47 4 19 hr. \_\_\_\_\_ min.

Immediate cause of death: Toxemia

Due to: Urinary Extravasation

9. Birthplace: Van Buren Arkansas  
(City, town, or county) (State or foreign country)

10. Usual occupation: Janitor

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Due to: 136 hr

MOTHER FATHER

11. Industry or business: Hartford Arms Apartment

12. Name: Henry Moore

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

14. Maiden name: Masseline Dickerson

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

PHYSICIAN

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant: Record Clerk

(b) Address: General Hospital #2

17. (a) burial (b) Date thereof: 8/5/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Blue Ridge Lawn

18. (a) Signature of funeral director: Hatkins Bros

(b) Address: 1729 Lydia

19. (a) 8-4-43 (b) W. E. Brown  
(Date received local registrar) (Registrar's signature)

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: J. G. Turner (M. D. or other) \_\_\_\_\_  
Address: Gen. Hosp. #2 - 600 E. 22nd Date signed: 7-31-43

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**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, fact should be so stated above.**