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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43087
Registrar's No. 91

FILED JAN 13 1943
Registration District No. 2313

Primary Registration District No. 5781

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

1. PLACE OF DEATH:

(a) County Miller

(b) City or town Rural - Gleizertown
(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 years, months or days)

In this community 9 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Miller

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

(d) Street No. Brunley - Mo. R#1
(If rural, give location)

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

3. (a) PRINT FULL NAME FRANKLIN JAMES MOORE

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Edash Moore

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased Feb 26 - 1877
(Month) (Day) (Year)

8. AGE: Years 66 Months 10 Days 3
If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name James Franklin Moore

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

14. Maiden name Eda Walker

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

16. (a) Informant Edash Moore

(b) Address Brunley - Mo. R#1

17. (a) Burial (b) Date thereof 12-31-43
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Ch. B. Busey

(b) Address St. Louis, Mo.

19. (a) 1-5-44 (b) C. H. Hawkes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 29
year 1943 hour 5 minute 8 P. M.

21. I hereby certify that I attended the deceased from Nov. 17, 1943, to Dec 29, 1943; that I last saw him alive on Dec. 29, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Uremic Coma

Due to Ca. of Prostate years, 4

Due to massive trauma in accidental injury Nov. 17, 1943.

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

Major findings: Of operations _____
Of autopsy _____

Duration 6 hr.

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) OC. 62

(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. J. Ayres (M.D. or _____)

Address Tusculum Mo. Date signed 1-4-44

RECEIVED

Miller County Health Dept.

County File Number 44-9

Date Filed 1-7-44

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 Chase

Licensed Embalmer No. 2694

P. O. Address Berea, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Jan.*
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County *Waller*
(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) (Specify whether

3. (a) PRINT FULL NAME *Franklin G. Moore*

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive *64* years

7. Birth date of deceased *Feb. 26 - 1918*
(Month) (Day) (Year)

8. AGE: Years *66* Months *10* Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____
(City, town, or county) (State or foreign country)

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)

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 *Dec* Day *29* Year *1943* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him/her alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death *Wemic coma* Duration _____

caused by prostate

Due to *Massive trauma in*

accidental injury Nov. 17 - 1943

Due to *Death was not*

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

Major findings: *due to* PHYSICIAN _____

Of operations *injury*

Of autopsy _____ 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) *Accident*

(b) Date of occurrence *Nov. 17 - 43*

(c) Where did injury occur? *Farm Residence*
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? *Home*

While at work? *yes* (Specify type of place) (e) Means of injury *fall*

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTAL

S-43683