

FILED MAY 5 1944

# MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

### CERTIFICATE OF DEATH

14564

Do not use this space.

## 1. PLACE OF DEATH

(a) County Franklin Registration District No. 103  
 (b) Township Long Primary Registration District No. 5417 Registered No. 6  
 (c) City Long (d) Street No. 1 St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred 8 yrs. 3 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

(a) Residence, No. Mary Dorothy Moore St. Mo  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Robert Allen Moore  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 20 1886  
 7. AGE YEARS 77 MONTHS 6 DAYS 11 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Wife  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kn

FATHER 13. NAME Robert Jones  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER 15. MAIDEN NAME Mary Hodge  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Robert Jones

18. BURIAL, CREMATION, OR REMOVAL PLACE Deshauss DATE 4/12/44

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Moore20. FILED 19

Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/31/44

22. I HEREBY CERTIFY, That I attended deceased from Mar 31 to Mar 31, 1944  
 I last saw him live on Mar 31, 1944 Death is said to have occurred on the date stated above, at 3 p m.  
 The principal cause of death and related causes of importance were as follows:

Influenza fac-1-1  
low by pneumonia  
3/20

Other contributory causes of importance:

Name of operation 33a Date of 3/20  
 What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? Date of injury 19  
 Where did injury occur? (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury 33a  
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify G. H. Moore  
 (Signed) James Moore M. D.  
 (Address) Moore

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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RECEIVED

District Health Office No. 2,

District File Number 144-629

Date Filed 4-12-44

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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, above space should be left blank.**



DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. may  
6  
Registrar's No. 6

Registration District No. 103

Primary Registration District No. 577

1. PLACE OF DEATH:

(a) County Dunklin  
(b) City or town Clay (If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Rural  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution (Specify whether)  
In this community (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME

Mary Allen

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 Albert 6. (c) Age of husband or wife if alive 1866

7. Birth date of deceased Aug 20 (Month) (Day) (Year)

8. AGE: Years 77 Months 6 Days 1 (less than one day) min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Robert

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

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

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

16. (a) Informant Cathie Robertson

(b) Address River, Mo

17. (a) (Burial, cremation, or removal) (b) Date thereof 4-2-47 (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director Batesville Ark

(b) Address 4-3-44

19. (a) (b) Linda P. Pukish (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin  
(c) City or town River (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 March day 3 year 1947 hour 1 minute 30 M.

21. I hereby certify that I attended the deceased from (Date) (Date) 19\_\_; that I last saw him/her alive on (Date) 19\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death Influenza following pneumonia Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

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) (e) Means of injury

23. Signature E. H. Cape (M. D. or other)

Address Batesville, Mo Date signed 4/3

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

SUPPLEMENTARY



14564