

FILED JUN 4 1944

State File No.

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 181

14
2
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton

(c) Name of hospital or institution: Callaway # 12
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 1 mo - 15
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo

(b) County Laclede

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

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME Marian Moore

3. (b) If veteran, name war.

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24
year 1944 hour 8 minute 24 A.M.

21. I hereby certify that I attended the deceased from 4-6-1944 to 5-24-1944
that I last saw him alive on 5-23-1944
and that death occurred on the date and hour stated above.
Immediate cause of death Brain tumor

4. Sex M

5. Color W race W

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

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

6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased: 7 (Month) 1 (Day) 1906 (Year)

Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 107

8. AGE: Years 60 Months 9 Days 0 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name Robt. L. Moore

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

14. Maiden name Josephine

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations

Of autopsy

16. (a) Informant Record

(b) Address

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?

17. (a) Removal (b) Date thereof 5-24-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Callaway Mo

18. (a) Signature of funeral director Callaway funeral home

(b) Address Callaway Mo

19. (a) 5-24-1944 (b) Josie M. ...
(Date received local registrar) (Registrar's signature)

23. Signature J. E. ... (M. D. or other) 5/24/44
Address Fulton Mo Date signed 5/24/44

JUN 16 1949

MAY 11 1949

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 6-6-44

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 R. A. Palmer
Licensed Embalmer No. 1161
P. O. Address Keokuk 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.