

S. No. 2  
M-8-43  
5-17-39  
I X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JUN 20 1944  
Registration District No. 277

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 22084  
Registrar's No. 386

Primary Registration District No. 5786

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

1. PLACE OF DEATH:  
 (a) County Mississippi  
 (b) City or town Charleston- (Rural) Miss  
 (c) Name of hospital or institution:  
R#2 Box 263  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
 In this community 12 years  
 years, months or days)

3. (a) PRINT FULL NAME Fannie Moore  
 3. (b) If veteran, name war.....  
 3. (c) Social Security No.....

4. Sex F 3 5. Color or race Colored  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Albert Moore  
 6. (c) Age of husband or wife if alive 34 years  
 7. Birth date of deceased February 24th 1900  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
44 2 0 ..hr. ..min.

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

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER  
 12. Name Ruben Harris  
 13. Birthplace N.K. Ark  
 (City, town, or county) (State or foreign country)  
 14. Maiden name N.K. N.K.  
 15. Birthplace N.K. N.K.  
 (City, town, or county) (State or foreign country)

16. (a) Informant Albert Moore  
 (b) Address R#2 Charleston, Mo.

17. (a) Burial (b) Date thereof 4-27-44  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Charleston, Mo.

18. (a) Signature of funeral director [Signature]  
 (b) Address [Address]

19. (a) (Date received local registrar) (b) Registrar's signature [Signature]

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Miss. 67  
 (c) City or town Charleston, (rural)  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. R#2 Box 263  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country 10

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24th  
 year 1944 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from No Medical attendance, 19.....  
 that I last saw h..... alive on..... 19.....  
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Indigestion  
Unprovoked  
 Due to.....  
 Due to.....

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

Major findings:  
 Of operations.....  
 Of autopsy.....  
 PHYSICIAN  
11813  
 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?

(Specify type of place) While at work..... (e) Means of injury Car  
 23. Signature [Signature] (M. D. or other)  
 Address [Address] Date signed 4/27/44

1257

RECEIVED

District Health Office No. 2,

District File Number 644-842

Date Filed 6-14-44

---

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

*John F. Hinkle Jr.*

Licensed Embalmer No. 3851

P. O. Address Charleston 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.**