

FILED JAN 20 1945

Registration District No. **47**

Primary Registration District No. **3008**

Registrar's No. **400**

1. PLACE OF DEATH
Callaway
(a) County **Fulton,**
(b) City or town **Fulton,**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
8 W 7th St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: **25 Years** in hospital or institution. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
Missouri
(a) State **Fulton** (b) County **Callaway 14**
(c) City or town **1**
(If outside city or town limits, write "RURAL") **2**
(d) Street No. **8 W 7th St**
(If rural, give location) **NO**
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country **(1)**

3. (a) PRINT FULL NAME **JAMES ED. MOORE**

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

4. Sex **Male 0** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed 2**

6. (b) Name of husband or wife **Nellie F. Moore** 6. (c) Age of husband or wife if alive **12** years **1869**

7. Birth date of deceased (Month) **June** (Day) **12** (Year) **1869**

8. AGE: Years **75** Months **5** Days **24** If less than one day hr. _____ min. _____

9. Birthplace **Callaway Co. Missouri**
(City, town, or county) (State or foreign country)
Stockman & Farming

10. Usual occupation _____

11. Industry or business **Thomas Moore**

12. Name **Thomas Moore** 13. Birthplace **Missouri**

14. Maiden name **Nancy Frances Jones** 15. Birthplace **Missouri**

16. (a) Informant **Gordon Moore** (b) Address **Fulton, Mo R.F.D.# 3**

17. (a) **Burial** (b) Date thereof **12: 8: 44**
(Burial, cremation, or removal) (Month) (Day) (Year)
Guthrie Cem.

18. (a) Signature of funeral director **Wallace Funeral Home**
7 W 6th St. Fulton, MO

19. (a) **12-8-1944** (b) **Joace Moore**
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **6th Dec** Day _____ Year **1944** hour **about 7 P.** minute _____ M. _____

21. I hereby certify that I attended the deceased from **was called after** 19____; that I last saw him **alive on** 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: **over dose of strychnine self administered** Duration _____

Due to _____

Due to _____

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

Major findings: Of operations **succeeding in getting a bottle of strychnine** Of autopsy **found in stomach which death could be charged to**
and died in few minutes

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? _____

23. Signature **W. Barrett Corvins** (M. D. or other) _____

Address **Dec 8 1944** Date signed _____

REQUESTED INFORMATION SUPPLEMENTARY ADDITIONAL

PHYSICIAN

MOTHER FATHER

RECEIVED

District Health Officer No.

District File Number _____

Date Filed 1-19-45

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 Denzil C. Brown

Licensed Embalmer No. 27264

P. O. Address Fulton Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. Feb
Registrar's No. 400

Registration District No. 41

Primary Registration District No. 3008

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton
(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 _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME James Ed. 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 W

6. (b) Name of husband or wife _____

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

7. Birth date of deceased June 12 1944
(Month) (Day) (Year)

8. AGE: Years 75 Months 5 Days 19
Unless than one day min.

9. Birthplace MO
(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 _____

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 Feb Day 13 Year 1944 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

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) suicide

(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? Retired (Specify type of place) _____

23. Signature W. J. Ferritt (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY 6

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

2B
3
36930

1855