

No. 2  
5-42  
17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED FEB 5 1945**

STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

2020

Registration District No. 71

Primary Registration District No. 3012

State File No. ....

Registrar's No. 9

**1. PLACE OF DEATH:**

(a) County Clay  
(b) City or town 706 Marietta St.  
(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 1  
(Specify whether  
In this community  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Clay 24  
(c) City or town Excelsior Springs  
(If outside city or town limits, write "RURAL")  
(d) Street No. 706 Marietta St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME William Samuel Moore

3. (b) If veteran, name war None 3. (c) Social Security No. ....

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lizzie 6. (c) Age of husband or wife if alive 20 years

7. Birth date of deceased January 20 1869  
(Month) (Day) (Year)

8. AGE: Years 75 Months 11 Days 16 If less than one day  
hr. min.

9. Birthplace Excelsior Springs / Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business

MOTHER FATHER {  
12. Name John Moore  
13. Birthplace Clay Co. Missouri  
14. Maiden name Rebecca Tarwater  
15. Birthplace Ray Co. Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ethel Kephart  
(b) Address Excelsior Springs, Missouri

17. (a) Burial (b) Date thereof 1-8-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill Cemetery

18. (a) Signature of funeral director Claude Buchanan

(b) Address Excelsior Springs, Mo.

19. (a) 1-8-45 (b) Mrs. Edna Redman  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month January day 6  
year 1945 hour 10 minute 30A. M.

21. I hereby certify that I attended the deceased from Nov. 19 1944 to Jan 5 1945  
that I last saw him alive on Jan 5 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Duration

Due to My father had  
prostatic gland

Other conditions Cerebral Emorrhage  
(Include pregnancy within 3 months of death)

Major findings: ADDITIONAL PHYSICIAN  
Of operations SUPPLEMENTARY Underline  
Of autopsy INFORMATION the cause to  
REQUESTED which death  
should be  
charged sta-  
tistically.

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 [Signature] (Date of death)  
Address Excelsior Springs, Mo. Date signed Jan 8 1945

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

2-2-40

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

Claude L. Charles

Licensed Embalmer No.

2757

P. O. Address

Excelsior Spgs.

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.

Registration District No. 21

Primary Registration District No. 3012

1. PLACE OF DEATH:

(a) County Clay  
(b) City or town Freshing River Twp  
(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)

3. (a) PRINT FULL NAME Wm S. Meade  
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 \_\_\_\_\_

7. Birth date of deceased Jan 20 1945  
(Month) (Day) (Year)

8. AGE: Years 75 Months 11 Days \_\_\_\_\_ (if less than one day) \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(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 Jan 1945 year \_\_\_\_\_ 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 Membrane Hypertension  
Due to prostate

Due to \_\_\_\_\_

Other conditions cerebral hemorrhage  
(Include pregnancy within 3 months preceding death)

Major findings: 830  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 J. P. Baird (M. D. or other) \_\_\_\_\_  
Address Exeter Springs Mo Date signed 1-2-45

SUPPLEMENTARY

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

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

