

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED MAR 27 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

2949

Registration District No.

42

Primary Registration District No.

1000

Registrar's No.

2739

1. PLACE OF DEATH:

(a) County Buchanan
 (b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Mo. Methodist Hosp
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 da
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

Charles Edward Moore3. (b) If veteran,
name war —3. (c) Social Security
No. —

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married,
 divorced Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
 alive _____ years

7. Birth date of deceased March 5 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 1 hr. _____ min.

9. Birthplace St Joseph Mo. 17
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

12. Name Dward Moore
 13. Birthplace Ill 1
(City, town, or county) (State or foreign country)

14. Maiden name Katherine
 15. Birthplace Mo 1
(City, town, or county) (State or foreign country)

16. (a) Informant Dward Moore
 (b) Address St Joseph, Mo.

17. (a) Burial (b) Date thereof 3-7-45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Memorial Park
FLEEMAN & SON, INC.

18. (a) Signature of funeral director _____
 (b) Address ST. JOSEPH, MO.

19. (a) 3-7-45 (b) Walter J. Pugh
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
 (c) City or town St Joseph 11
(If outside city or town limits, write "RURAL")
 (d) Street No. 3323 Mitchell
(If rural, give location)
 (e) Citizen of foreign country? No 0 (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6
 year 1945 hour 9 minute 45 P.M.

21. I hereby certify that I attended the deceased from 3-6-45
 _____ 19____ to 3-6-45 19____;
 that I last saw him alive on 3-6-45 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death

atelectasis

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 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?

C. _____

While at work? _____ (Specify type of place)
 (c) Means of injury _____

23. Signature W. B. Peterson M. D. or other) _____
 Address 624 Francis Date signed 3-7-45

(Licensed Embalmer's Statement on Reverse Side)

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

1277

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

working under my personal supervision.

Registered Apprentice No.

Signed

Robert L. Gable

Licensed Embalmer No.

3308

P. O. Address

St Joseph, 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.