

FILED MAR 18 1945

Registration District No. _____

Primary Registration District No. 5771

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Mercer
(b) City or town Rural Marion Twp.
(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 _____
In this community 72 yrs. II Mos. 15 days
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Mercer
(c) City or town Rural Marion Twp.
(d) Street No. _____
(e) Citizen of foreign country? No
If yes, name country: _____

3. (a) PRINT FULL NAME Randolph Moore

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

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

6. (b) Name of husband or wife Ida Moore 6. (c) Age of husband or wife 7 years

7. Birth date of deceased Feb. 29, 1873
(Month) (Day) (Year)

8. AGE: Years 72 Months II Days 15 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer Retired

11. Industry or business Own Farm

12. Name Robert Moore

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

14. Maiden name Hester Jewett

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

16. (a) Informant James E. Moore

(b) Address Cheyenne Wyo.

17. (a) Burial (b) Date thereof Feb. 17/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moore Cemetery

18. (a) Signature of funeral director O. O. Greenlee

(b) Address Lineville Iowa

19. (a) 2/19/45 (b) Don Mathison
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 14 year 1945 hour 10 minute _____ M.

21. I hereby certify that I attended the deceased from May 5 1935 to Feb 14 1945
that I last saw him alive on Feb 5 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: myocarditis & heart block chronic nephritis
Due to slendity

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

Major findings: _____
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) (c) Means of injury _____

23. Signature Dr. J. M. Perry (M. D.) _____
Address Princeton Mo Date signed 2/15/45

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

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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 *Amos L. Greenlee*

Licensed Embalmer No. *2901*

P. O. Address *Summerville, S.C.*

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.