

FILED APR 16 1945
Registration District No. 339

Primary Registration District No. 4527

Registrar's No. 38

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Bronaugh Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 28 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Vernon

(c) City or town Bronaugh Mo. 117
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? no 11 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME ANDREW W. MOORE

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 24
year 1945 hour 2:40 minute A.M.

21. I hereby certify that I attended the deceased from Mar 20, 1945 to Mar 24, 1945
that I last saw him alive on Mar 22, 1945
and that death occurred on the date and hour stated above.

4. Sex M/D 5. Color or race W 6. (a) Single, widowed, married, divorced M.

6. (b) Name of husband or wife Charlotte Moore 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased Oct 1865
(Month) (Day) (Year)

Immediate cause of death Hypostatic pneumonia, 3da
Duration _____

Due to Cardiac failure

Due to Cerebral hemorrhage

8. AGE: Years 79 Months 5 Days 15 If less than one day hr. min.

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

10. Usual occupation Retired Section Foreman

11. Industry or business _____

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

Major findings: Of operations _____

Of autopsy 830

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

MOTHER, FATHER { 12. Name John Moore

13. Birthplace Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Mrs. A. W. Moore

(b) Address Bronaugh Mo

17. (a) Burial (b) Date thereof Mar 25, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bronaugh Mo

18. (a) Signature of funeral director G. B. Berry & Sons

(b) Address Sheldon, Mo

19. (a) Mar 28, 1945 (b) G. T. Dyer
(Date received local registrar) (Registrar's signature)

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 M. H. Kulland (M. D. or other) D.O.
Address Liberale, Mo Date signed Mar 25, 1945

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

RECEIVED
Health Officer NE 77
3-4-45
4-13-45
APR 25 1945

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. ~~9385~~

working under my personal supervision.

Signed..... *Carroll T. Beery*

Licensed Embalmer No. *2385*

P. O. Address *Sheldon 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.