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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 24 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25963

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7069

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: Barnes Hospital, 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County 999

(c) City or town Little Rock 3 NR
(If outside city or town limits, write "RURAL")

(d) Street No. 1820 North Monroe 0
(If rural, give location)

(e) Citizen of foreign country? no. 2 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Dr Robert Booth Moore

3. (b) If veteran, name war no

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Lena Belle Moore

6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased July 22nd 1888 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
57		19	hr. min.

9. Birthplace Searcy (City, town, or county) Arkansas (State or foreign country)

10. Usual occupation Physician

11. Industry or business

FATHER
12. Name L. E. Moore
13. Birthplace Arkansas (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mattie Booth
15. Birthplace Searcy (City, town, or county) Arkansas (State or foreign country)

16. (a) Informant Lena B. Moore
(b) Address Little Rock Arkansas.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/12/45 (Month) (Day) (Year)
(c) Place: burial or cremation Little Rock, Arkansas

18. (a) Signature of funeral director Wagoner Mortuary
(b) Address 4161 Lindell Blvd.

19. (a) AUG 12 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 12th year 1945 hour 12 minute 00 A.M.

21. I hereby certify that I attended the deceased from July 30, 1945, to August 12, 1945 that I last saw him alive on August 12, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Lymphosarcoma	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy None performed

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

23. Signature H R Bradley (M. D.)
Address Barnes Hospital, Date signed 8/12/45

(Licensed Embalmer's Statement on Reverse Side)

Municipal Ctr Bldg
R 110 Bureau of
Vital Statistics

APR 5 1946

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 Neville B. Strohwitter

Licensed Embalmer No. 3696

P. O. Address 4161 Lindell Blvd

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.