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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

FILED AUG 29 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 613

1. PLACE OF DEATH:

(a) County Greene
 (b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
738 South Street
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution None
(Specify whether)
 In this community 85 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
 (c) City or town Springfield
(If outside city or town limits, write "RURAL")
 (d) Street No. 738 South Street
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Robert Allis Moore

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

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

6. (b) Name of husband or wife UNK.
 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased May 11, 1846
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>99</u>	<u>2</u>	<u>23</u>	hr. _____ min.

9. Birthplace UNK New York
(City, town, or county) (State or foreign country)

10. Usual occupation In Home

11. Industry or business _____

MOTHER FATHER
 12. Name Robert Nelson Moore
 13. Birthplace Lyons New York
(City, town, or county) (State or foreign country)
 14. Maiden name Sarah Pollok
 15. Birthplace Lyons New York
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Ruth W. Moore

(b) Address Springfield, Missouri

17. (a) Burial (b) Date thereof Aug. 7, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 8-7-45 (b) BY W. E. Hausley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 4th,
 year 1945 hour 11:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from 1940 to Aug 4, 1945
 that I last saw him alive on Aug 4, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
 Duration 4 Days

Due to Senility and Arterio-sclerosis

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: None
 Of operations None
 Of autopsy None

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) No
 (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? _____ (b) Means of injury _____

23. Signature W. E. Hausley (M. D. or other) _____
 Address Springfield mo Date signed 8-7-45

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

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.....

Lewis G. Scherpf

Licensed Embalmer No. *3802*

P. O. Address. *Springfield, 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.

X