S. No. 2
M—2-43
. 5-17-39
I X35657

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 7 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 32815
4404

Registration District No. 149 Primary Registration District No. 102 Registrar's No.

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas cy
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C.T.B Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 year - 5 mo 18 days
In this community 23 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas cy (If outside city or town limits, write "RURAL")
(d) Street No. 1707½ E 18th (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MOORE, ARTHUR
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex M 2
5. Color or race N.
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased April (Month) 13 (Day) 1946 (Year)
8. AGE: Years 29 Months 6 Days 10 If less than one day hr. min.
9. Birthplace Rockdale (City, town, or county) Texas (State or foreign country)
10. Usual occupation Laborer
11. Industry or business
FATHER
12. Name Garfield Moore
13. Birthplace Tex (City, town, or county) Tex (State or foreign country)
MOTHER
14. Maiden name Anna Walker
15. Birthplace Tex (City, town, or county) Tex (State or foreign country)
16. (a) Informant K.C.T.B. Hospital
(b) Address Kansas cy Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/45 (Month) (Day) (Year)
(c) Place: burial or cremation Blue Ridge Lawn
18. (a) Signature of funeral director Watkins Bros
(b) Address 1729 Lydia
19. (a) 10-26-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 23 year 1945 hour 3 minute 00 P.M.
21. I hereby certify that I attended the deceased from 3-3-44, 19 to 10-23, 1945 that I last saw him alive on 10-23, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	1½ yr
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 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 D. L. Coffman (M. D. or other) M.D.
Address Kansas City, Mo Date signed 10-23-45

(Licensed Embalmer's Statement on Reverse Side)

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 J. J. Manlove

Licensed Embalmer No. 3994

P. O. Address 2503 Highland

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.