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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33391

FILED OCT 31 1945

Registration District No. 5-452 Primary Registration District No. 5-187 5189 Registrar's No.

1. PLACE OF DEATH:

(a) County Cape Co.

(b) City or town Rural W. el. Twp.
(If outside city or town limits, write "RURAL" and name of township)

(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 —
(Specify whether In this community 19 year years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County SCOTT 100

(c) City or town CHAFFEE /
(If outside city or town limits, write "RURAL")

(d) Street No. 125 W. PARKER /
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) /

If yes, name country

3. (a) PRINT FULL NAME DWIGHT-O-MOORE

3. (b) If veteran, name war WORLD-WAR-2 3. (c) Social Security No. 490-24-8905

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

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

7. Birth date of deceased Feb. (Month) 17 (Day) 1926 (Year)

8. AGE: Years 19 Months 6 Days 00 If less than one day — hr. min.

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

10. Usual occupation Radio Oper

11. Industry or business —

FATHER
12. Name T. C. Moore
13. Birthplace WILSON KAN. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name NELLIE ALEXANDER.
15. Birthplace FAIR GROVE MO. (City, town, or county) (State or foreign country)

16. (a) Informant TEX. Moore, F
(b) Address Chaffee Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Mem Park Cape Girardeau

18. (a) Signature of funeral director Bujeling Hott Funeral Mo
(b) Address Chaffee Mo Home

19. (a) Aug 23 1945 (Date received local registrar) (b) A. H. Macke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 17 year 1945 hour 4 minute p. M.

21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Drowning	
Due to Stepping in a hole while wading in ~~a creek~~ the Diversion Channel	
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) Accident 16

(b) Date of occurrence Aug. 17, 1945

(c) Where did injury occur? Allenville (City or town) Cape (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In Diversion Channel (Specify type of place)

While at work? (e) Means of injury

23. Signature Dr. J. F. Sigmund Coroner (M. D. or other)

Address Jackson Mo Date signed 8/18/45

1158 (Licensed Embalmer's Statement on Reverse Side)

Health Officer No. 4
District File Number 1045-1237
Date Filed 10-30-45

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 Mamie Bryslinghoff

Licensed Embalmer No. 32 42

P. O. Address Chaffee 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.

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Nov

Registration District No. 54 Primary Registration District No. ( ) Registrar's No.

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Rural (Wetch Twp.)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community (Lived at Chaffee, Mo all life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

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

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

If yes, name country

3. (a) PRINT FULL NAME Dwight O Moore

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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 Feb (Month) 17 (Day) 19 (Year)

8. AGE: Years 19 Months 6 Days 00 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 11-23-45 (Date received local registrar) (b) D. G. Seibert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 7 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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 Dr. J. F. Sigmund (M. D. or other) Coroner

Address Jackson, Mo. Date signed

SUPPLEMENTARY

33391