. No. 2
-11-10-39
5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 14 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34357

Registration District No. 276 Primary Registration District No. 4410 Registrar's No. 7

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

1. PLACE OF DEATH:
(a) County: Phelps
(b) City or town: ST. James (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST. James Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 hrs (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Phelps 81
(c) City or town: Rural (If outside city or town limits, write "RURAL") 0
(d) Street No.: Rolla Twp. (If rural, give location) 0
(e) If foreign born, how long in U. S. A.? years.

8. (a) PRINT FULL NAME: Infant Moore
8. (b) If veteran, name war:
8. (c) Social Security No.:
4. Sex: Male
5. Color or race: W
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: October (Month) 19 (Day) 1945 (Year)

8. AGE: Years | Months | Days | If less than one day: 4 hr. min.

9. Birthplace: ST. James (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: ✓
11. Industry or business: ✓

MOTHER FATHER
12. Name: Wilfred Moore
13. Birthplace: Phelps Co. (City, town, or county) Mo (State or foreign country)
14. Maiden name: Freida Harris
15. Birthplace: Phelps Co. (City, town, or county) Mo (State or foreign country)

16. (a) Informant: Wilfred Moore
(b) Address: Rolla, Rt. 1, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 20 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Rolla, Mo
18. (a) Signature of funeral director: Smith-Hollow
(b) Address: Rolla, Mo.
19. (a) (Date received local registrar) (b) (Registrar's signature)

1467

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 19 year 45 hour 4 minute 30 M.
21. I hereby certify that I attended the deceased from 10-19, 1945, to 10-19, 1945; that I last saw alive on 10-19-45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Congenital Development of Heart
Due to: Premature Birth
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations:
Of autopsy: 159

Duration

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: [illegible] M.D. (M. D. or other)
Address: [illegible] Date signed 10/20/45

(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 Not Embalmed, Registered Apprentice No. ....., working under my personal supervision.

Signed [illegible]

Licensed Embalmer No. 3643

P. O. Address Rolla, 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, above space should be left blank.

. No. 2B
M—3-45
I X43880

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. 1102

Registration District No. 276 Primary Registration District No. 4410 Registrar's No. 7.

1. PLACE OF DEATH:

(a) County Phelps

(b) City or town Jamer
(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 years, months or days)

In this community

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 — 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 Oct 19 (Month) (Day) 1900 (Year)

8. AGE: Years Months Days 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) (Date received local registrar) (b) Ora E. Birmingham (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 19 year 1944 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.

Immediate cause of death — Duration

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

34357