

S. No. 2
7-8-43
5-17-39
PI X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37816

State File No. _____

FILED NOV 16 1945

Registrar's No. 599

Registration District No. 784

Primary Registration District No. 3038

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

1. PLACE OF DEATH:

(a) County LINN

(b) City or town BROOKFIELD
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1310 N MAIN
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no (Specify whether)

In this community ten years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn

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

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

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ALFRED MOORE

(b) If veteran, name war no

(c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 25
year 1945 hour 7:30 minute am

4. Sex M Color or race W

5. (a) Single, widowed, married, divorced Y

6. (b) Name of husband or wife _____ (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased August (Month) 14 (Day) 1854 (Year)

21. I hereby certify that I attended the deceased from March 10, 1940 to Oct 23, 1945
that I last saw him alive on Oct 23, 1945
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

91 2 11 hr. min.

Immediate cause of death Stroke

Due to _____

Due to _____

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

10. Usual occupation Retired farmer

Other condition General arteriosclerosis
(Include pregnancy within 3 months of death)

Duration 20 yrs

11. Industry or business _____

12. Name Billy Moore

13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings: _____
Of operations 97

Of autopsy _____

Underline the cause to which death should be charged statistically.

14. Maiden name unknown

15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Nettie Welch
(b) Address 1310 N Main

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? _____

17. (a) Burial (b) Date thereof Oct 27-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant View Cem

18. (a) Signature of funeral director Brookfield Home
(b) Address 443 W. Brookfield, Mo

19. (a) 10/27/45 (b) Evelyn Kelley Deputy
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) _____ (Specify means of injury)

23. Signature Ray R. Haley (M. D. or other) 91-0
Address Brookfield, Mo Date signed 10/26/45

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..... *C. A. Larson*.....

Licensed Embalmer No. *4037*.....

P. O. Address..... *Bucklin, 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.