

FILED DEC 12 1945
Registration District No. **217**

Primary Registration District No. **3045**

Registrar's No. **91**

1. PLACE OF DEATH:
 (a) County **Mississippi**
 (b) City or town **Charleston**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
620 West Marshall St. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **22 years** (Specify whether
 In this community _____ years, months or days)

3. (a) PRINT FULL NAME **Hattie Moore**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female 3** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced, **Widowed**
 6. (b) Name of husband or wife **Lewis Moore** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **December 1, 1892**
 (Month) (Day) (Year)

8. AGE: Years **52** Months **11** Days **19** If less than one day _____ hr. _____ min.

9. Birthplace **Cary, Mississippi** (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Andrew Williams**

13. Birthplace **Jackson, Mississippi** (City, town, or county) (State or foreign country)

14. Maiden name **Anna Bradford**

15. Birthplace **Cary, Mississippi** (City, town, or county) (State or foreign country)

16. (a) Informant **Ollie Williams (brother)**

(b) Address **620 W. Marshall St.**

17. (a) Burial (b) Date thereof **Nov. 25, 1945**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove Cemetery**

18. (a) Signature of funeral director **F. J. Sparks**

(b) Address **Cape Girardeau, Mo.**

19. (a) 11-36-45 (b) **ms. John Boudarant**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Mississippi 69**
 (c) City or town **Charleston** (If outside city or town limits, write "RURAL")
 (d) Street No. **620 West Marshall St.** (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **20** year **1945** hour **6:00** minute _____ P. M.

21. I hereby certify that I attended the deceased from **Sept 23** 19**45** to **Nov 20** 19**45**
 that I last saw her alive on **Nov 20** 19**45** and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Vase. Renal Disease** Duration **3 mo +**

Due to _____

Due to _____

Other conditions **Arteriosclerosis D.K.**
 (Include pregnancy within 3 months of death)

Major findings:
 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) _____

(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? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature **E. Chas. Oliver** (M. D. or other) _____
Charleston Mo Address Date signed **11/24/45**

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

1541

RECEIVED
District Health Office No. 2
District File Number 1245-3347
Date Filed 12/6/45

DEC 19 1945

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

Frank Sparks

Licensed Embalmer No.

3455

P. O. Address

Cape Verde

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.