

S. No. 2  
DM-5-43  
v. 5-17-39  
I X36671

20411

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 2720

Registration District No. 149 Primary Registration District No. 1002

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

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution: St. Luke's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 days  
In this community 15 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Kansas (b) County 999  
(c) City or town Ottawa  
(If outside city or town limits, write "RURAL")  
(d) Street No. 720 South Sycamore  
(If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country X

3. (a) PRINT FULL NAME Mrs. Judith A. Moore  
3. (b) If veteran, name war no. 3. (c) Social Security No. no.  
4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Eli B. Moore, 6. (c) Age of husband or wife if alive dec. years  
7. Birth date of deceased July 17 1902  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June day 16 year 1946 hour 5:00 minute P. M.  
21. I hereby certify that I attended the deceased from May 23, 1946, to June 16, 1946, that I last saw her alive on June 16, 1946, and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
43 10 29 hr. min.

Immediate cause of death Cerebral hemorrhage Duration 20 hrs.

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

Due to 30 g

10. Usual occupation housewife

Other conditions O.K. (Include pregnancy within 6 months of death) To go to  
Chloroform Anesthetics 10 yrs  
PHYSICIAN

11. Industry or business X

Major findings: Of operations \_\_\_\_\_  
Of autopsy X  
Underline the cause to which death should be charged statistically.

12. Name Howard Colaw

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

14. Maiden name Bessie L. Bland (City, town, or county) (State or foreign country)

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

16. (a) Informant David Moore,  
(b) Address 330 Main St., Osawatomie, Kansas

17. (a) removal (b) Date thereof 6-17-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Ottawa, Kansas,

18. (a) Signature of funeral director Stine & McClure,  
(b) Address 3235 Gillham Plaza, K. C., Mo.

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 Homer Stine (M. D. or other) \_\_\_\_\_  
Address 3235 Gillham Plaza, K. C., Mo. Date signed 6/17/46

19. (a) 6-19-46 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

*Med Playe*  
*Baldy*

Dr. P. T. Bohan

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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. Allen*  
Licensed Embalmer No. *1415*  
P. O. Address *190*

**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.