

5-543  
5-17-39  
1 X36671

**FILED** AUG 1 1946  
Registration District No. **303**

Primary Registration District No. **3074**

Registrar's No. **45**

**1. PLACE OF DEATH:**  
(a) County **Scott**  
(b) City or town **Sikeston**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**518 Park 1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days) **Life**

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **Mo** (b) County **Scott 10<sup>th</sup>**  
(c) City or town **Sikeston**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **518 Park**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **JOHN FRANKLIN MOORE**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **July** day **20**  
year **1946** hour **10** minute **30 P. M.**  
**21. I hereby certify that I attended the deceased for 20 years**  
\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him alive on **7-19** 19**46**  
and that death occurred on the date and hour stated above.

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 **March 11 1906**  
(Month) (Day) (Year)

Immediate cause of death **poisoning of Barbiturates**  
**Phenobarbital**  
Due to **accidental overdose of Barbiturates**  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

**8. AGE:** Years **40** Months **4** Days **9** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace **Sikeston Mo**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **Farmer**

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) **accidental**  
(b) Date of occurrence **7-20-46**  
(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 \_\_\_\_\_

**MOTHER, FATHER**  
12. Name **A. J. Moore**  
13. Birthplace **New Madrid Mo**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Frances Ann Burnate**  
15. Birthplace **Sikeston Mo**  
(City, town, or county) (State or foreign country)  
16. (a) Informant **Mrs. Henrietta Root**  
(b) Address **Sikeston Mo**  
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **7-23-46**  
(Month) (Day) (Year)  
(c) Place: burial or cremation **City Cemetery**  
18. (a) Signature of funeral director **Wesley Turner Bone**  
(b) Address **Sikeston Mo**  
19. (a) **7-27-46** (Date received local registrar) (b) **Mrs. J. F. Henry** (Registrar's signature)

23. Signature **Sheldon C. McClain** (M. D.)  
Address **Sikeston Mo** Date signed **7-23-46**

**303**

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

RECEIVED  
District Health Office No.  
District File Number 746-925  
Date Filed 7-31-46

AUG 21 1946

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 Raymond Crews  
Licensed Embalmer No. 3467  
P. O. Address Sikeston 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 499  
Registrar's No. \_\_\_\_\_

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Scott  
(b) City or town Sikeston  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days)

3. (a) PRINT FULL NAME John 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 W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Mar (Month) 19 (Day) 19 (Year)

8. AGE: Years 40 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day \_\_\_\_\_ min.)

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

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

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

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
1790

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accidental  
(b) Date of occurrence July 20 - 1946  
(c) Where did injury occur? His home - Dekeston Mo. (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 Thomas C. McClure (M. D. or other) \_\_\_\_\_  
Address Dekeston, Mo. Date signed 8-27-46

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

24790

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

25943