

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 90

Registration District No. 741 Primary Registration District No. 3025

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

1. PLACE OF DEATH:  
(a) County Howell  
(b) City or town West Plains  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Christa Hogan Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 0 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Howell  
(c) City or town West Plains  
(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 R. B. Moore  
(b) If veteran, name war V  
(c) Social Security No. ✓

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 9 day 14 year 1946 hour 2 minute 40 P. M.  
21. I hereby certify that I attended the deceased from 9/13 1946 to 9/14 1946 that I last saw him alive on 9/14 1946 and that death occurred on the date and hour stated above.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced 1  
(b) Name of husband or wife Mattie Gibbs Moore 6. (c) Age of husband or wife if alive 66 years  
7. Birth date of deceased 8/31/1875  
(Month) (Day) (Year)

Immediate cause of death Intestinal Obstruction  
Duration \_\_\_\_\_

8. AGE: Years 71 Months 13 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) Intestinal Obstruction

9. Birthplace Bowling Green, Mo.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Farmer

Major findings: Intestinal Adhesions with Obstruction of lumen  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
12. Name Robert Moore  
13. Birthplace Pike, Co. Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary S. Huff  
15. Birthplace Lucien, Co. Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. R. B. Moore  
(b) Address West Plains, Mo.  
17. (a) B (b) Date thereof 9-17-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

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? \_\_\_\_\_

(c) Place: burial or cremation Dripping Springs  
18. (a) Signature of funeral director Robert D. ...  
(b) Address West Plains, Mo.  
19. (a) Oct. 8, 1946 (b) Gladys Harrison  
(Date received local registrar) (Registrar's signature)

(Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or O.D.)  
Address West Plains, Missouri Date signed 9/18/46

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RECEIVED

District Health Officer No. 5,

District File Number 1046569

Date Filed 10-17-46

JUN 5 1950

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.....

L. L. Duncan....., Registered Apprentice No. 390  
working under my personal supervision.

Signed..... A. A. Roberts.....

Licensed Embalmer No. 3432

P. O. Address West Plains, 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.