

FILED AUG 6 1948

Registration District No. ....

Primary Registration District No. 3041

Registrar's No. 351

1. PLACE OF DEATH:

(a) County Macon  
(b) City or town Macon  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Samaritan Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shelby  
(c) City or town Shelbina  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1  
(If rural, give location)  
(e) Citizen of foreign country? ..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME

Grant Moores

3. (b) If veteran, name war.....

3. (c) Social Security No. ....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11th  
year 1948 hour 9 minute A.M.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased October 26th 1868  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12-1-47 to July 11 1948  
that I last saw him live on July 11 1948  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
79 8 15 hr. min.

Immediate cause of death:  
Pulmonary embolism 18 hrs  
Due to arteriosclerosis  
gangrene of leg 3 mo  
due to arteriosclerosis indistinct

9. Birthplace Adams Co Ill  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Farming

12. Name Linus Moores

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

14. Maiden name Caroline Gates

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

16. (a) Informant Mrs Challis Steffan

(b) Address Shelbina Mo

17. (a) Burial (b) Date thereof 7/13/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shelbina Mo.

18. (a) Signature of funeral director Million & Barkeley

(b) Address Shelbina Mo.

19. (a) 7-23-48 (b) Paul McNeely  
(Date received local registrar) (Registrar's signature)

Other conditions (Include pregnancy within 3 months of death) ✓

Major findings:  
Of operations arteriosclerosis  
occlusion of femoral  
artery and thigh  
amputation of leg

PHYSICIAN  
Underline the cause of 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 Paul McNeely (M. D. or other) MD

Address Shelbina Mo Date signed 7-16-48

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 8-48-16

Date Filed AUG. 4 - 1948

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 \_\_\_\_\_

*Henry G. Larkelaw*

Licensed Embalmer No. \_\_\_\_\_

3835

P. O. Address \_\_\_\_\_

*Shelburne, 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.