

FILED JUL 2 1 1948

Registration District No. **233** Primary Registration District No. **3074**

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:
Sikeston General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 weeks** (Specify whether
In this community **All of life** years, months or days)

3. (a) PRINT FULL NAME **James William Moore**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Mary Ann Moore** 6. (c) Age of husband or wife if alive **Deceased** years
7. Birth date of deceased **February 8th 1872**
(Month) (Day) (Year)

8. AGE: Years **76** Months **4** Days **21** If less than one day hr. min.

9. Birthplace **Saline County Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business **Retired**

MOTHER FATHER

12. Name **John Wesley Moore**
13. Birthplace **Illinois**
(City, town, or county) (State or foreign country)
14. Maiden name **Sarah Stephens**
15. Birthplace **Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Florence Rister**
(b) Address **412 Kathleen St., Sikeston, Mo**
Burial (b) Date thereof **7/1/1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maynard Cem. Diehlstadt, Mo**
18. (a) Signature of funeral director **John G. Hume**
Charleston, Mo
(b) Address

19. (a) **7-19-48** (b) **Mo J. G. Henry**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Scott** **100**
(c) City or town **Sikeston, Mo R#2** **0**
(If outside city or town limits, write "RURAL")
(d) Street No. **RFD #. 2** **0**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **29th**
year **1948** hour **10:** minute **40** P. M.

21. I hereby certify that I attended the deceased from **May 15** 19**48** to **June 29** 19**48**
and that death occurred on the date and hour stated above.
that I last saw him alive on **June 28** 19**48**

Immediate cause of death **myocarditis** Duration

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations **936**
Of autopsy
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 **John G. Hume** (M. D. or other)
Address **Sikeston Mo** Date signed **7-19-48**

RECEIVED

District Health Office No. 2

District File Number 748-911

Date Filed 7-22-48

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 *John F. Minnielee*
Licensed Embalmer No. 3851

P. O. Address *Charleston*

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.