

Registration District No. **198**

Primary Registration District No. **5423**

Registrar's No. **21**

1. PLACE OF DEATH:

(a) County **Dunklin**
 (b) City or town **Arbyrd Rural Salem**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **State line, 4 mile South Leachville Ark**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Dollie Ann Francis Moore**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Deceased** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **January 29 1893**
(Month) (Day) (Year)

8. AGE: Years **55** Months **5** Days **18** If less than one day _____ hr. _____ min.

9. Birthplace **Hornersville Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. INDUSTRY OR BUSINESS

12. Name **Samuel H. Buck**

13. Birthplace **Unknown Tenn**
(City, town, or county) (State or foreign country)

14. Maiden name **Margie Ann Burns**

15. Birthplace **Coldwater Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Lando L. Moore**

(b) Address **Arbyrd, Mo**

17. (a) **Burial** (b) Date thereof **7-18-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lulu Cemetery, Arbyrd, Mo**

18. (a) Signature of funeral director **Howard Funeral Service**

(b) Address **Leachville, Arkansas**

19. (a) **9-8-1948** (b) **Mr J. H. Lanier**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Dunklin**
 (c) City or town **Arbyrd Rte 1**
(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** day **16**
 year **1948** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **never**
 _____, 19____, to _____, 19____;
 that I last saw him _____ alive on **never**, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death **fractured skull** Duration _____

Due to **Train hitting car she was riding in pickup**
 Due to _____

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

Major findings: Of operations **170 C**

Of autopsy **23**

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) **accident**

(b) Date of occurrence **16 July 48**

(c) Where did injury occur **State line Ark + Mo 136**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place

While at work? _____ (e) Means of injury _____

23. Signature **T N Robman** (M. D. or other) **MD**

Address **Leachville Ark** Date signed **30 July 48**

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

MOTHER FATHER

SEP 14 1948

RECEIVED

District Health Office No. 2

District File Number 918-114

Date Filed 9-10-48

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 H. H. Howard

Licensed Embalmer No. 3959

P. O. Address Leachville Ark

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.