

FILED MAR 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8381**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **5466** Registrar's No. **235**

390

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

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lawrence	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Rural—South Campbell Twp)		c. CITY (If outside corporate limits, write RURAL and give township) Lawrenceburg 0550	
c. LENGTH OF STAY (In this place) 10 days		d. STREET ADDRESS (If rural, give location) 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION OZARK OSTEOPATHIC HOSPITAL			

3. NAME OF DECEASED a. (First) John b. (Middle) Thomas c. (Last) Moore			4. DATE OF DEATH (Month) (Day) (Year) 3 14 50			
5. SEX Male	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 2-2-1863	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Months 1 Days 12	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Missouri 0		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Andrew Moore		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Alice Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Mrs. Grace Brazeal ADDRESS Ash Grove, Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Prostatic Hypertrophy		
	11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **2/4**, 19**50**, to **3/14**, 19**50**, that I last saw the deceased alive on **3/14**, 19**50**, and that death occurred at **7:10 A m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. A. Michael Do.		23b. ADDRESS Springfield, Mo.		23c. DATE SIGNED 3/14/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-16-50	24c. NAME OF CEMETERY OR REMATORY DUNKEL Cemetery	24d. LOCATION (City, town, or county) (State) Lawrence Co. Mo.	
DATE REC'D BY LOCAL REG. 3-15-50	REGISTRAR'S SIGNATURE W. S. Hardley	25. FUNERAL DIRECTOR'S SIGNATURE Wm. Funeral Service Ash Grove Mo. ADDRESS		

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 _____

..... Student Embalmer No.

working under my personal supervision.

Signed Harold D. White

Signed.....
Student Embalmer

Licensed Embalmer No. 4605

P. O. Address Ch. Gene 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.