

**STANDARD CERTIFICATE OF DEATH**

State File No. **41810**  
 Registrar's No. **185**

FILED DEC 11 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **333** PRIMARY REG. DIST. NO. **3074**

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)	
a. COUNTY <b>Scott</b>	b. COUNTY <b>Scott</b> <b>1000</b>		
b. CITY OR TOWN <b>Sikeston</b>	c. LENGTH OF STAY (in this place) <b>0 hours</b>	c. CITY OR TOWN <b>Benton</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mo. Delta Community Hosp.</b>		e. STREET ADDRESS (If rural, give location) <b>Gen. Del.</b>	

<b>3. NAME OF DECEASED</b> (Type or Print)	a. (First) <b>Elizabeth</b>	b. (Middle) <b>—</b>	c. (Last) <b>Moore</b>	<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>11 27 1953</b>
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<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>10-18-1882</b>	<b>9. AGE</b> (In years last birthday) <b>71</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Dunklin Co., Missouri</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
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<b>13a. FATHER'S NAME</b> <b>Will Norman</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Mary Ann Romaine</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>T. J. Moore</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	<b>16. SOCIAL SECURITY NO.</b> <b>—</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Herbert Moore, Benton, Mo.</b>	<b>ADDRESS</b>
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<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Myocardial Infarction</b>		
	<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>arteriosclerotic Cardiovascular disease</b> DUE TO (c) <b>disease</b>		
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.			

<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>4201</b>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>
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<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) m.	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>
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**22. I hereby certify that I attended the deceased from 11-20, 1953, to 11-27, 1953, that I last saw the deceased alive on 11-27, 1953, and that death occurred at 11:05A m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> (Degree or Title) <b>Alfred Sargent</b>	<b>23b. ADDRESS</b> <b>Sikeston, MO</b>	<b>23c. DATE SIGNED</b> <b>11-28-53</b>
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<b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>	<b>24b. DATE</b> <b>11-29-53</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>City</b>	<b>24d. LOCATION</b> (City, town, or county) (State) <b>Sikeston MO</b>
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<b>DATE REC'D BY LOCAL REG.</b> <b>12-3-53</b>	<b>REGISTRAR'S SIGNATURE</b> <b>Mrs. Ella Hunter</b>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Welch Funeral Home - Sikeston MO</b>	<b>ADDRESS</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED DEC 7 1953  
SCOTT COUNTY HEALTH CENTER  
CO. FILE NO. 1953-260

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..

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Raymond Crews*

Licensed Embalmer No. 34  
P. O. Address *Liberton*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.