

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26850**

BIRTH NO. **FILED AUG 16 1954** REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **772**

1. PLACE OF DEATH a. COUNTY hickeda Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY hickeda	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN haganon	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hosp.		d. STREET ADDRESS (If rural, give location) 538 N Washington Ave	

3. NAME OF DECEASED a. (First) William b. (Middle) B. c. (Last) Moore			4. DATE OF DEATH (Month) (Day) (Year) Aug. 10 1954		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 6 1886	9. AGE (In years last birthday) 68	10. UNDER 1 YEAR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ar. Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) hickeda Co. MO.	12. COUNTRY OF WHAT COUNTRY? USA.

13a. FATHER'S NAME Oliver Brown	13b. MOTHER'S MAIDEN NAME Mary Wilson	14. NAME OF HUSBAND OR WIFE Frank Moore
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT'S SIGNATURE OR NAME Ernest Brown ADDRESS haganon 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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Venia		INTERVAL BETWEEN ONSET AND DEATH 4 weeks.
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Unknown - Autopsy result pending		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from **7-24**, 1954, to **8-10**, 1954, that I last saw the deceased alive on **8-10**, 1954 and that death occurred at **1:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE: Homer Marshall, M.D. (Degree or title)	23b. ADDRESS: Post Bldg Springfield	23c. DATE SIGNED: 8-11-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 8-11-54	24c. NAME OF CEMETERY OR CREMATORY haganon	24d. LOCATION (City, town, or county) (State) haganon MO.
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DATE REC'D BY LOCAL REG. 8-11-54	REGISTRAR'S SIGNATURE Ernest Williamson	25. FEDERAL DIRECTOR'S SIGNATURE Homer Marshall ADDRESS Springfield MO.
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(Licensed Embalmer's Statement on Reverse Side)

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

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Lewis G. Schaefer

Signed.....
Student Embalmer

Licensed Embalmer No. *3802*

P. O. Address *Springfield, 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.