

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1957**

FILED FEB 14 1955

BIRTH NO. _____ REG. DIST. NO. **267** PRIMARY REG. DIST. NO. **5911** Registrar's No. **32**

780
1

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

1. PLACE OF DEATH a. COUNTY Pemiscot		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Pemiscot	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Pascola Rural	c. LENGTH OF STAY (Specify place) 3 yrs.	c. CITY OR TOWN Pascola	d. Is Residence within limits of city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Rural Route 1		e. STREET ADDRESS (If rural, give location) Rural Route 1	0780

3. NAME OF DECEASED (Type or Print) a. (First) Angie b. (Middle) c. (Last) Moore	4. DATE OF DEATH (Month) (Day) (Year) Jan. 30, 1955
---------------------------------------------------------------------------------------------------------	---------------------------------------------------------------

5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 29, 1907	9. AGE (In years last birthday) 47	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
----------------------	-------------------------------	-----------------------------------------------------------------------	---------------------------------------	-------------------------------------------	-----------------------------------------	------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-Wife	10b. KIND OF BUSINESS OR INDUSTRY X	11. BIRTHPLACE (City and State or Foreign Country) Tyronza, Arkansas	12. CITIZENSHIP OF WHAT COUNTRY U.S.A.
---------------------------------------------------------------------------------------------------------------	--------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------

13a. FATHER'S NAME George Pitts	13b. MOTHER'S MAIDEN NAME Anna Reed	14. NAME OF HUSBAND OR WIFE E. J. Moore
----------------------------------------	--------------------------------------------	------------------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. X	17. INFORMANT'S SIGNATURE OR NAME E. J. Moore	ADDRESS Poplar Bluff, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Cerebral Hemorrhage ANTECEDENT CAUSES Possibly Hypertension DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 2 hrs unknown
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	-----------------------------------------------------------------

19a. DATE OF OPERATION	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) (Min.)	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 **29 Jan, 1955, to 30 Jan, 1955**, that I last saw the deceased alive on **30 Jan, 1955**, and that death occurred at **1 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Julia Ke (Degree or title) M.D.	23b. ADDRESS Caruthersville, Mo.	23c. DATE SIGNED 2-1-55
--------------------------------------------------------------	-----------------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-1-55	24c. NAME OF CEMETERY OR CREMATORY Homestown Cemetery	24d. LOCATION (City, town, or county) (State) Wardell, Mo.
---------------------------------------------------------	-------------------------	--------------------------------------------------------------	-------------------------------------------------------------------

DATE REC'D BY LOCAL REG. 2-1-55	REGISTRAR'S SIGNATURE John W. German 406-70	25. FUNERAL DIRECTOR'S SIGNATURE Osburn Funeral Home	ADDRESS Wardell, Mo.
----------------------------------------	-----------------------------------------------------------	-------------------------------------------------------------	-----------------------------

2-42-55

PEMISCOT COUNTY HEALTH DEPARTMENT
COURTHOUSE PHONE 79
CARUTHERSVILLE, MO.

FEB 10 1955

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.....
Licensed Embalmer No. 4185

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