

FILED OCT 3 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29699

State File No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>292</u>	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Kirksville,</u>		c. LENGTH OF STAY (in this place) <u>1 day</u>		c. CITY OR TOWN <u>LaCrosse</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Grim Smith Hospital & Clinic</u>				STREET ADDRESS (If rural, give location) <u>0.610</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ronnie</u>		b. (Middle) <u>Ernest</u>		c. (Last) <u>Moore</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>9 24 56</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>1-3-95</u>	
9. AGE (In years last birthday) <u>61</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>21</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>			
13a. FATHER'S NAME <u>William Thomas Moore</u>			13b. MOTHER'S MAIDEN NAME <u>Lizzie Armstrong</u>			14. NAME OF HUSBAND OR WIFE <u>Nellie Hazel Moore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Nellie H. Moore</u>		ADDRESS <u>LaCrosse, Missouri</u>	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cor pulmonale</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Pulmonary fibrosis</u> <u>History of inhalation of gas - 1 World War I.</u> DUE TO (c) <u>Light Spontaneous pneumothorax</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Light Spontaneous pneumothorax</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u> <u>40 yrs</u> <u>1 mo.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>525X</u>				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 <u>8-10, 1956</u> , to <u>9-24, 1956</u> , that I last saw the deceased alive on <u>9-24, 1956</u> , and that death occurred at <u>4:39 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>[Signature]</u> (Degree or title)				23b. ADDRESS <u>Kirksville, Mo.</u>		23c. DATE SIGNED <u>9-25-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Sept 26, 1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>La Plata Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>La Plata Mo.</u>	
DATE REC'D BY LOCAL REG. <u>9-28-56</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Clemens Wilson</u>		ADDRESS <u>La Plata, Mo.</u>	

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

OCT 9
1951

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 *Hennet M. Wilson*.....

Licensed Embalmer No. *H. 201*

P. O. Address *La Plata N.*

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.