

FILED JUN 10 1957

Registration District No. 141

Primary Registration District No. 3025

Registrar's No. 53

300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

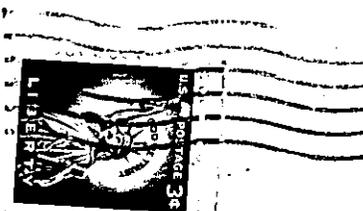
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY HOWELL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY HOWELL	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WEST PLAINS,		c. CITY OR TOWN WEST PLAINS,	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION STOLL HOSP.,		d. STREET ADDRESS (If outside, give location) 1112 Washington	
3. NAME OF DECEASED First Middle Last AMANDA WILLARD MOORE		4. DATE OF DEATH Month Day Year 5-25-57	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-11-1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY X	11. BIRTHPLACE (City and state or country) BREGON COUNTY, MO
13a. FATHER'S NAME J. P. WILLARD		13b. MOTHER'S MAIDEN NAME BETTY COMBS	14. NAME OF HUSBAND OR WIFE X
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) X		16. SOCIAL SECURITY NO. X	
17. INFORMANT Address RICHARD MOORE, MICHIGAN CITY, IND.,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage hemiplegia essential hypertension with arteriosclerosis DUE TO (b) years DUE TO (c) years			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 331X	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 5 23 57 to 5 25 57 and last saw her alive on 5 25 57 Death occurred at 4:30 PM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J J B Scott M D		22b. ADDRESS West Plains MO	22c. DATE SIGNED 6 1 57
23a. BURIAL, CREMATION, REMOVAL (Specify) B	23b. DATE 5-27-57	23c. NAME OF CEMETERY OR CREMATORY UNION HILL	23d. LOCATION (City, town, or county) (State) THOMASVILLE, MO
24. FUNERAL DIRECTOR ADDRESS ROBERTSONS, WEST PLAINS, MO		25. DATE RECD. BY LOCAL REG. 6-4-57	26. REGISTRAR'S SIGNATURE Beatrice Cook

79
0

West Plains MO

Robertsons Funeral Home



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 *D. S. Roberts*

Licensed Embalmer No. *3430*

P. O. Address *West Plains*

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.