

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037409
STATE FILE NUMBER

FILED NOV 7 1958 Registration District No. 290 Primary Registration District No. 5985 Registrar's No. 165

1. PLACE OF DEATH a. COUNTY Pulaski			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pulaski		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fort Leonard Wood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Fort Leonard Wood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION US Army Hospital		Length of stay in lb --	STREET ADDRESS (If outside, give location) US Army Hospital		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First BYRON Middle EUGENE Last MOORE			4. DATE OF DEATH Month October Day 27 Year 1958		
5. SEX Male	6. COLOR OR RACE 2 Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Oct 58	9. AGE (In years last birthday) 1	IF UNDER 1 YEAR Months 1 Days 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) Ft Leonard Wood, Mo 0		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Kenneth E Moore		13b. MOTHER'S MAIDEN NAME Shirley M Clavon		14. NAME OF HUSBAND OR WIFE -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -----	17. INFORMANT Kenneth E Moore Address Ft Leonard Wood, Mo		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hyaline membrane disease					
DUE TO (c) 7730					
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 checked="" type="checkbox"/> NO <input 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.)		
20c. TIME OF INJURY Hour 8:40 Month Oct Day 26 Year 1958 a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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 26 Oct 58 to 27 Oct 58 and last saw him alive on 27 Oct 58 Death occurred at 8:40 P m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>H. Baruch</i> H. BARUCH (Degree or title) Capt MC			22b. ADDRESS US Army Hospital Ft Leonard Wood, Missouri		22c. DATE SIGNED 28 Oct 58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct 30, 1958	23c. NAME OF CEMETERY OR CREMATORY Post Cemetery		23d. LOCATION (City, town, or county) (State) Ft Leonard Wood Missouri	
24. FUNERAL DIRECTOR HEDGES FUNERAL HOMES INC CROCKER MO ADDRESS 10-30-58			25. DATE RECD. BY LOCAL REG. 10-30-58		26. REGISTRAR'S SIGNATURE <i>Paula Mae Anderson</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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. *Not Embalmed*

Student
Signature of Student Embalmer

Signed *Harrie Shwer*

: Licensed Embalmer No. *4896*

P. O. Address *Waynesville, N.C.*

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.