

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-018016

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Registration District No. _____ Primary Registration District No. 3074 Registrar's No. 110

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Scott</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Scott</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u>		Length of stay in 1b		c. CITY OR TOWN <u>Sikeston</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>228 North West St.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>228 North West St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Leander</u> Middle <u>David</u> Last <u>Moore</u>				4. DATE OF DEATH Month <u>4</u> Day <u>19</u> Year <u>1960</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11/6/1875</u>		9. AGE (last birthday) <u>84</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>13</u> Hours _____ Min. _____		IF UNDER 24 HR	
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) <u>Muhlenberg Co. Ky.</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>				
13a. FATHER'S NAME <u>Unknown--</u>				13b. MOTHER'S MAIDEN NAME <u>Unknown</u>				14. NAME OF HUSBAND OR WIFE <u>Maud Moore</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Martha Hodges, Sikeston, Mo.</u> Address _____							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>										INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Stroke</u>										<u>24 hrs</u>			
DUE TO (c) <u>Age and Arteriosclerotic Vascular disease</u>										<u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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.)									
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year											
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 <u>4-19-60</u> to <u>4-19-60</u> and last saw him alive on <u>4-19-60</u> Death occurred at: <u>9: P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>John Sargent MD</u>						22b. ADDRESS <u>707 Tanner St Sikeston Mo</u>				22c. DATE SIGNED <u>4-23-60</u>			
23a. BURIAL, CREMATION, REMOVAL, SPECIFY <u>Burial</u>		23b. DATE <u>4/22/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Garden Of Memories</u>			23d. LOCATION (City, town, or county) <u>Sikeston, Mo.</u>			(State)			
24. FUNERAL DIRECTOR <u>Albritton Funeral Home, Sikeston, Mo.</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>4-26-60</u>		26. REGISTRAR'S SIGNATURE <u>Mr. Elliot Hunter</u>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Raymond L. Ruffin

Licensed Embalmer No. 4798

P. O. Address Bonnie, TN

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.