

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-036125

STATE FILE NUMBER

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 269

AMENDED

FILED NOV 14 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Callaway</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Warren</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u> | | Length of stay in 1b <u>8 years</u> | c. CITY OR TOWN <u>Warrenton</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 1</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>State Hospital No. 1, Fulton, Mo.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Moore</u> Last <u>Moore</u> | | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>1961</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-10-1896</u> |
| 9. AGE (last birthday) <u>65</u> | | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u> | 11. BIRTHPLACE (City and state or country) <u>Warrenton, Mo.</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>Frank Moore</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>R. Tildy ?</u> | | 14. NAME OF HUSBAND OR WIFE <u>unk</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u> | | 16. SOCIAL SECURITY NO. <u>unk</u> | 17. INFORMANT Address <u>State Hospital No. 1, Fulton, Mo.</u> |
| 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>Cardiac Arythmia</u> recent and old myocardial infarctions DUE TO (b) <u>recent cerebral vascular accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u>recent cerebral vascular accident</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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 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 <u>11:25 A.M.</u> a.m. p.m. | Month, Day, Year <u>5-10-1953</u> to <u>11-9-1961</u> | 20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>State Hospital No. 1</u> <u>Fulton, Mo.</u> | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21. Attended the deceased from <u>11:25 A.M.</u> to <u>11:25 A.M.</u> Death occurred at <u>11:25 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE. (Degree or title)- <u>William V. Faricelli, M.D.</u> | | 22b. ADDRESS <u>Fulton, Mo.</u> | 22c. DATE SIGNED <u>11/10/61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>11-12-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Mexico, Mo.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Arnold Funeral Home, Mexico Mo.</u> | | 25. DATE REGD. BY LOCAL REG. <u>Nov-10-1961</u> | 26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u> |

NOV 16 1961

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

Richard J. Mc Donald

Licensed Embalmer No. 4825

P. O. Address Mexico, 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.