

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040121

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 685

FILED NOV 20 1961

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Audrain</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in lb <u>24 days</u>	c. CITY OR TOWN <u>Mexico</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>University Medical Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>704 East Jackson</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Dennis Talmage Moore</u>			4. DATE OF DEATH Month Day Year <u>11 12 61</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>2-23-86</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-----------------------	----------------------------------	---	------------------------------------	-------------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Dentist</u>	11. BIRTHPLACE (City and state or country) <u>Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S</u>
---	---	---	---

13a. FATHER'S NAME <u>William Coleman Moore</u>	13b. MOTHER'S MAIDEN NAME <u>Fannie Bell Mallory</u>	14. NAME OF HUSBAND OR WIFE <u>Vona Moore</u>
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>University Medical Records, Columbia Mo</u>
---	-------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> INTERVAL BETWEEN ONSET AND DEATH <u>25 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Subdural &amp; Epidural Hematoma</u> <u>25 days</u>
	DUE TO (c) <u>Fall - sustaining head injury</u> <u>25 days</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Skull fracture, Hypostatic pneumonia</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
--	---

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Fall in street 10-18-61</u>
--	--	--

20c. TIME OF INJURY Hour a.m. p.m. <u>Noon 10-18-61</u>
---

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>sidewalk - street</u>	20f. CITY, TOWN, OR LOCATION <u>Mexico</u>	COUNTY <u>Audrain</u>	STATE <u>Mo.</u>
---	--	---	--------------------------	---------------------

21. I attended the deceased from 10-19-61 to 11-12-61 and last saw her/him alive on 11-11-61  
Death occurred at 9:40 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>L. R. Russell MD</u>	22b. ADDRESS <u>UMMC Columbia Mo</u>	22c. DATE SIGNED <u>11-12-61</u>
---	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-14-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Mexico Mo</u>
--	------------------------------	--	---

24. FUNERAL DIRECTOR <u>Fred Houston</u>	ADDRESS <u>Mo. Mexico</u>	25. DATE RECD. BY LOCAL REG. <u>Nov. 12 1961</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>
---	------------------------------	---	--

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

NOV 27 1961

NOV 28 1961

AUG 28 1962

NOV 20 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 Earl E. Pruitt

Licensed Embalmer No. 3189

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.