

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-005481

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 032 Primary Registration District No. _____ Registrar's No. 415

FILED FEB 27 1962

AMENDED

1. PLACE OF DEATH a. COUNTY <u>BOLLINGER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence, before admission) a. STATE <u>Mo</u> b. COUNTY <u>Carter</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lutesville</u>		Length of stay in 1b <u>9 mo</u>	c. CITY OR TOWN <u>Van Buren</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>Bond Nursing home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>VAN BUREN</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Watter</u> Middle _____ Last <u>MOORE</u>			4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>62</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>Sept 20-1891</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fishing Guide</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Boating</u>	11. BIRTHPLACE (City and state or country) <u>SHANNON Co. Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>William Moore</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Hanger</u>	14. NAME OF HUSBAND OR WIFE <u>Dead</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. _____	17. INFORMANT <u>W.D. Moore</u> Address <u>10331 Quaker Dr. St Louis 36 Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (b), stating the underlying cause last.	DUE TO (b) <u>Carcinomatous</u>	
	DUE TO (c) <u>(Primary) throat</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
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19. WAS AUTOPSY PERFORMED? YES <input 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 _____ 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 1/3/62 to 2/11/62 and last saw ^{her}him alive on 2/11/62
Death occurred at 3 O'CLOCK A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John F. Myers MD</u>	22b. ADDRESS <u>Lutesville Mo</u>	22c. DATE SIGNED <u>2/21/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2-11-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Van Buren</u>
		23d. LOCATION (City, town, or county) (State) <u>Van Buren Mo</u>

24. FUNERAL DIRECTOR <u>Gene Ward, Lutesville Mo</u> ADDRESS _____	25. DATE RECD. BY LOCAL REC. <u>2/23/62</u>	26. REGISTRAR'S SIGNATURE <u>Mr Buford Crader</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

MAR 1 1962

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 *J. Tennant Riley*

Licensed Embalmer No. 5086

P. O. Address Lutesville W

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.