DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 9 1947

Registration District No. 381

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Simpson

State File No. 43268

Primary Registration District No. 45 1/2

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Sullivan
(b) City or town Milan
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: —
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
(Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Sullivan
(c) City or town Milan
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME William Harrison Moore

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced W. Divorced

6. (b) Name of husband or wife Mattie M. Williams

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased Feb (Month) 10 (Day) 1874 (Year)

8. AGE: Years 72 | Months 10 | Days 12 | If less than one day ___ hr. ___ min.

9. Birthplace Coon (City, town, or county) Mo (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business

MOTHER
12. Name Austin Moore
13. Birthplace W. Va. (City, town, or county) (State or foreign country)

FATHER
14. Maiden name America Cassity
15. Birthplace Lee Co. (City, town, or county) Iowa (State or foreign country)

16. (a) Informant Mrs Nellie Harris
(b) Address Milan Mo

17. (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 12/23/46 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Zion

18. (a) Signature of funeral director Schoene's
(b) Address Milan Mo

19. (a) Jan 6-1947 (Date received local registrar) **(b)** Mrs. H. B. Harris (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22 year 1946 hour 9 minute 20 A.M.

21. I hereby certify that I attended the deceased from Dec. 20 - 1946, to Dec. 22 1946, that I last saw h/ he alive on Dec. 21 1946 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Malignancy of Neck,	6 mo
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Ira Simpson (M. D. or other) MD
Address Milan Date signed 12-24-46

(Licensed Embalmer's Statement on Reverse Side)

REGISTERED
DISTRICT REGISTRAR No. 10
DATE OF REGISTRATION JAN 7 1947

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Dwight L. Dikeman

Licensed Embalmer No. 2667

P. O. Address Nelson - 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 this body is not embalmed, fact should be so stated above.

S. No. 2B
5M—3-45
I X43080

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 381 Primary Registration District No. 4515 Registrar's No.

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town Milan
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Wm. H. Moore

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive Years

7. Birth date of deceased Feb 10 67
(Month) (Day) (Year)

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) MO (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day

year 1942 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;

that I last saw h alive on , 19 ;

and that death occurred on the date and hour stated above.

Immediate cause of death

Duration

Cancer of Neck 5 5E

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Treated a Ellis Fischer.

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

S-43268