

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

33308
Do not use this space.

1. PLACE OF DEATH

(a) County Randolph Registration District No. 735
 (b) Township Prairie Sugar Creek Primary Registration District No. 3034
 (c) City Moberly (d) Street No. McCormick Hospital St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 100-0 James A. Moore St. (If nonresident, give city or town and State)
RFD Moberly (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|--|--|
| 3. SEX <u>Male</u> | 4. COLOR OR RACE <u>White</u> | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF | | |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>May 18th 1922</u> | | |
| 7. AGE YEARS <u>17</u> | MONTHS <u>3</u> | DAYS <u>21</u> |
| If LESS than 1 day, _____ hrs. or _____ min. | | |
| OCCUPATION | 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>School Boy</u> | |
| | 9. Industry or business in which work was done, as saw mill, bank, etc. | |
| | 10. Date deceased last worked at this occupation (month and year) | |
| | | 11. Total time (years) spent in this occupation |
| 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Chariton Co Mo</u> | | |
| FATHER | 13. NAME <u>Orvil Moore</u> | |
| | 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Randolph Co Mo.</u> | |
| MOTHER | 15. MAIDEN NAME <u>Blanche Mann</u> | |
| | 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Iowa.</u> | |
| 17. INFORMANT <u>Orville Moore</u> (ADDRESS) <u>R. F. D. Moberly Mo</u> | | |
| 18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Moberly Mo</u> DATE <u>Sept 11 1939</u> | | |
| 19. FUNERAL DIRECTOR <u>Joe W. Burton</u> (ADDRESS) <u>Higbee Mo.</u> | | |
| 20. FILED <u>Sept 11 1939</u> <u>Leah Williams</u> Local Registrar | | |

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 9 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept 7 1939 to Sept 9 1939
 I last saw him alive on Sept 9 1939 Death is said to have occurred on the date stated above, at 2:10 A.M.
 The principal cause of death and related causes of importance were as follows:
Peritonitis Date of onset 9-6

Other contributory causes of importance:
Some intestinal disorder 8-27

Name of operation none Date of _____
 What test confirmed diagnosis? Blood count Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify McCormick Hospital, M. D.
 (Signed) McCormick
 (Address) Moberly Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

124
RECEIVED

District Health Officer No. 10

District File Number 10-39-1826

Date Filed OCT-11-1939

STATEMENT BY LICENSED EMBALMER

I, Paul T. Miller, Licensed Embalmer No. 2866

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. or by, Registered Apprentice No.
working under my personal supervision.

Signed Paul T. Miller

Licensed Embalmer No.

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.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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33308
Do not use this space.

1. PLACE OF DEATH
(a) County Randolph Registration District No. 735
(b) Township Moberly Primary Registration District No. 3034 Registered No. _____
(c) City Moberly (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME James A. Moore
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) s

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
17 3 21

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER
13. NAME _____
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
15. MAIDEN NAME _____
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-9, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:
Petechionitis N. M. Date of onset 1939

Other contributory causes of importance:
Some intestinal Disorders N. M. & cause unknown

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) F. L. McCarroll, M. D.
(Address) Moberly Mo

SUPPLEMENTARY

Local Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

