

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.

Registration District No. 2916

Primary Registration District No. 5760

Registrar's No. 110

1. PLACE OF DEATH:  
 (a) County Lincoln  
 (b) City or town Rural  
 (c) Name of hospital or institution: Brookfield Ins  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 69 years  
 In this community 69 years  
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Linn  
 (c) City or town Brookfield - Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. R. 7. D # 2  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Fred A Moore 600

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Bird Moore 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased August 27 1870  
 (Month) (Day) (Year)

8. AGE: Years 69 Months 3 Days 12 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name William G. Moore

13. Birthplace Howard County - Mo.  
 (City, town, or county) (State or foreign country)

14. Maiden name Eliza Lee

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

16. (a) Informant's own signature Bird Moore

(b) Address Brookfield - R. 7. D

17. (a) \_\_\_\_\_ (b) Date thereof Dec 16 - 39  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Cemetery - Brookfield

18. (a) Signature of funeral director Will Chapel

(b) Address Brookfield

19. (a) Dec 9 - 39 (b) Goodman  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Dec 9 day 9  
 year 1939 hour 6:00 minute 0 A. M.

21. I hereby certify that I attended the deceased from Nov 9, 1938 to Dec 9, 1939;  
 that I last saw him alive on Dec 8, 1939;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia

Due to Defected Hemorrhoids Ulcer 3 wks

Due to Post. Latent Syphilis 4 yrs

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Sam Evans (M. D. or other) \_\_\_\_\_

Address Brookfield Mo Date signed 12-10-39

Duration 1 wk.  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

**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.....

*J. H. Blacklock*

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

working under my personal supervision.

Signed

*J. H. Blacklock*

Licensed Embalmer No. *2246*

P. O. Address *Brookfield 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, above space should be left blank.**