

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9811
Registrar's No. 1245

Registration District No. 399

Primary Registration District No. 1002

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

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.

1. PLACE OF DEATH:

(a) County JACKSON
(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: HOME
(If not in hospital or institution, write street number or location) 7
(d) Length of stay: In hospital or institution 28 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME MRS. FANNIE I. MOORE
3. (b) If veteran, Fannie I. Moore name war NO
3. (c) Social Security No. 60-1

4. Sex FEMALE 5. Color or race WA
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife JOHN W
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased APRIL 21 - 1856
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>10</u>	<u>27</u>	hr. min.

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

10. Usual occupation Home

11. Industry or business

MOTHER FATHER
12. Name GOLSON - STAPP
13. Birthplace MO
(City, town, or county) (State or foreign country)
14. Maiden name FELAND
15. Birthplace DONT KNOW KY
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Fannie I. Moore
(b) Address 5914 Forest
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-40
(Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Suddath Funeral
(b) Address Home
19. (a) 3-20-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County JACKSON
(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")
(d) Street No. 5914 FOREST
(If rural, give location)
(e) If foreign born, how long in U. S. A. ✓ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19
year 1940 hour 8 minute P. M.
21. I hereby certify that I attended the deceased from February 1st, 1940, to March 19, 1940;
that I last saw her alive on March 15, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Decompensating heart. Duration

Due to Mitral Stenosis. Byra.

Due to 92nd

Other conditions (Include pregnancy within 3 months of death)

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?

While at work? (Specify type of place) (e) Means of injury
23. Signature A. H. Graham (M. D. or other) M.D.
Address 518 Argyle Bldg. Date signed 3/20/40

7/31 Passes

8-

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 Howard J. Roe

Licensed Embalmer No. 2748

P. O. Address K-C Mo

11/5/37

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.