

Registration District No. 508

Primary Registration District No. 3026

Registrar's No. 57

1. PLACE OF DEATH:

(a) County Livingston  
 (b) City or town Chillicothe  
 (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) 8  
 (d) Length of stay: In hospital or institution ✓ (Specify whether)  
 In this community Life years, months or days

3. (a) PRINT FULL NAME Lucinda Paris 670  
 3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced Divorced  
 6. (b) Name of husband or wife John Paris 6. (c) Age of husband or wife if alive 80 years  
 7. Birth date of deceased August 28 1863  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>7</u>	<u>21</u>	<u>✓</u> hr. <u>—</u> min.

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

10. Usual occupation At Home

11. Industry or business ✓

12. Name William Carr

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

14. Maiden name Unknown

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

16. (a) Informant's own signature Mr. Albert Donelson

(b) Address Chillicothe, Mo.

17. (a) Burial (b) Date thereof Apr. 19 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Edgewood Cem

18. (a) Signature of funeral director James D. Gordon

(b) Address Chillicothe, Mo.

19. (a) 4-20-1940 (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston  
 (c) City or town Chillicothe  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 129 E. Jackson  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19  
 year 1940 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from April 15  
4 to April 17, 1940  
 that I last saw her alive on April 16, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertatic pneumonia 3 day  
 Duration \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to 23

Other conditions: pulmonary myopia  
 (Include pregnancy within 3 months of death)  
tuberculosis

Major findings: none  
 Of operations \_\_\_\_\_

Of autopsy none  
 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?  
942

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

28. Signature J. J. Freeman (M. D. or \_\_\_\_\_)  
 Address Chillicothe, Mo. Date signed 4/20/40

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.

115618

RECEIVED

District Health Officer No. 11.

District File Number

570-695

Date Filed

MAY 9 1948

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.....

*James D Gordon*

Licensed Embalmer No.....

1270

P. O. Address.....

*Lehullicott*

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 15399  
Registrar's No. 59

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 308

Primary Registration District No. 3026

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD  
MOTHER FATHER  
WILSON MOORE

1. PLACE OF DEATH:

(a) County: Linn  
(b) City or town: Chillicothe  
(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.  
In this community (Specify whether 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) If foreign born, how long in U.S.A.?..... years.

3. (a) PRINT FULL NAME

Lucinda Paris

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

4. Sex: F 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..... year

7. Birth date of deceased: Aug 28 1863  
(Month) (Day) (Year)

8. AGE: Years 76 Months 6 Days 21 If less than one day..... h..... min.

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

10. Usual occupation.....

11. Industry or business.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 4-20-40 (b) H. M. Grace, M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 17 year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on..... and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Duration

Due to.....

Due to.....

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: R. J. Brennan (M. D. or other).....  
Address: Chillicothe, Mo. Date signed.....

