

State File No. _____

AY 15 1940
Registration District No. 609

Primary Registration District No. 5808

Registrar's No. 59

1. PLACE OF DEATH:
(a) County NEWTON
(b) City or town RURAL
(c) Name of hospital or institution:
COUNTY INFIRMARY
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

3. (a) PRINT FULL NAME ALVIN MOORE
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased UNKNOWN
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
ABOUT 45 hr. min.

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

10. Usual occupation 9

11. Industry or business FARMER

MOTHER FATHER
12. Name UNKNOWN
13. 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 COUNTY INFIRMARY
(b) Address NEWTON COUNTY

17. (a) BURIAL (b) Date thereof 4-23-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation COUNTY INFIRMARY

18. (a) Signature of funeral director Barley Thompson
(b) Address Neosho, Mo

19. (a) 5-2-40 (b) Whark Salem
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County NEWTON
(c) City or town RURAL NEOSHO
(d) Street No. _____
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 22
year 1940 hour Some time minute about 11
21. I hereby certify that I attended the deceased from Apr 19
1940, to Apr 22 1940
that I last saw him alive on Apr 19 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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? 542
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature R. L. Harrison (M. D. or other) _____
Address Neosho Mo Date signed _____

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

RECEIVED

District Health Officer No. 6,

District File Number 540-1289

Date Filed MAY 13 1940

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.....

Paul K. Gay, Registered Apprentice No. 189
working under my personal supervision.

Signed Coley Thompson

Licensed Embalmer No. 3259

P. O. Address Neosho 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.