

FILED OCT 11 1940

31022

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3585

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 2510 Jackson
(If not in hospital or institution, write street number or location) 30
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 6 months
years, months or days

3. (a) PRINT FULL NAME Charles D. Moore

3. (b) If veteran, Charles D. Moore (c) Social Security name war _____ No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced _____

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
appt 45 hr. min.

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

10. Usual occupation Soldier

11. Industry or business USA

12. Name unknown

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 Albert Freedy

(b) Address 217 Ogden St. Leawood Kan

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

(c) Place: burial or cremation Fort Leavenworth

18. (a) Signature of funeral director Marjorie Floyd

(b) Address 2315 Lincoln Blvd

19. (a) Sept. 13, 1940 (b) M. M. Brower
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1108 Forest
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 13
year 1940 hour _____ minute 10 P M.

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

Immediate cause of death Pneumonia by Aspiration
(Pending Autopsy findings)

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration

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 5

23. Signature Robert Koller (M. D. or other) _____
Address _____ Date signed 9/13/40

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

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.....

Roy E. Snow

Licensed Embalmer No. 2560

P. O. Address 2915 Lincoln Blvd

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. **3585**

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

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:
2516 Jackson
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community **6 months** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Charles D. 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

6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive year

7. Birth date of deceased. (Month) (Day) (Year)

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

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

10. Usual occupation **Soldier, U.S.A.**

11. Industry or business

12. Name **unknown**

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

14. Maiden name 15. Birthplace **unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Albert Freed**

(b) Address **217 Augur, Ft. Leavenworth,**

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

(c) Place: burial or cremation

18. (a) Signature of funeral director **Mayberrys Funeral Home**

(b) Address **2315 Linwood**

19. (a) **9/13/40** (Date received local registrar) (b) **M M Brown** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits write "RURAL")
(d) Street No. **1108 Forest**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **13** year **1940** hour **1** minute **10 P** M.

21. I hereby certify that at **11:10 P** I saw the deceased from **1940** to **1940** and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Coronary thrombosis**

Due to

Due to

Other conditions **94B**
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **See form**

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) **9/28/40**
Means of injury

23. Signature **Albert Freed** (M. D. or other)

Address **Linwood** Date signed

SUPPLEMENTARY

5-31022