

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39212
Registrar's No. 317

DEC 17 1940
Registration District No. 1547

Primary Registration District No. 3079

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2801 Carroll St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) 20

3. (a) PRINT FULL NAME Jydia Moore

3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color Negro 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Mart Moore 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 9 25 1886
(Month) (Day) (Year)

8. AGE: Years 54 Months 1 Days 4 If less than one day hr. _____ min. _____

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

10. Usual occupation Domestic

11. Industry or business

MOTHER FATHER
12. Name Sam Ruben
13. Birthplace Mo
(City, town, or county) (State or foreign country)
14. Maiden name Laura Ruben
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hedra Howard
(b) Address 2801 Carroll St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-40
(Month) (Day) (Year)

(c) Place: burial or cremation Robinson

18. (a) Signature of funeral director H. E. Roberts
(b) Address Hannibal Mo

19. (a) Nov 13-1940 (Date received local registrar) (b) H. E. Roberts (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marion
(c) City or town Hannibal
(If outside city or town limits, write "RURAL")
(d) Street No. 2801 Carroll St
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 29
year 1940 hour 5 minute 50 M.

21. I hereby certify that I attended the deceased from Dec 5 1938 to Oct 29-40, 19____;
that I last saw her alive on 10/28/40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Arterial Insufficiency
Due to _____

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

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 _____
23. Signature H. E. Roberts (M. D. or other) _____
Address Hannibal Mo Date signed 11/1/40

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.

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.....

Licensed Embalmer No.....

P. O. Address.....

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.