

FILED MAR 16 1944

Registration District No. 42Primary Registration District No. 2007Registrar's No. 72

1. PLACE OF DEATH:

Butler
 (a) County Butler
 (b) City or town Poplar Bluff
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Brandon Hospital
 (If not in hospital or institution, write street number and location)
 (d) Length of stay: In hospital or institution 5 days
 (Specify whether
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

Mo. 18
 (a) State Mo. (b) County Carter
 (c) City or town Van Buren
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Esther Moore3. (b) If veteran,
name war _____3. (c) Social Security
No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Walter Moore 6. (c) Age of husband or wife if alive 52 years
 7. Birth date of deceased May 3 1892
 (Month) (Day) (Year)

8. AGE: Years 51 Months 7 Days 20 If less than one day
 hr. _____ min. _____

9. Birthplace Carter County Mo.
(City, town, or county) (State or foreign country)
Housewife

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER } 12. Name Charles Hoskins
 13. Birthplace _____
 (City, town, or county) (State or foreign country)
 14. Maiden name Doshia Stevens
 15. Birthplace _____
 (City, town, or county) (State or foreign country)

16. (a) Informant Walter Moore
(b) Address Van Buren Mo.

17. (a) Burial (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Phil A. Leuckel
(b) Address Van Buren Mo.19. (a) 3-4-44 (b) Belle Kimmel
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 23
year 1944 hour 12 minute 45 P. M.21. I hereby certify that I attended the deceased from Feb. 7, 1944 to Feb. 17, 1944
that I last saw her alive on Feb. 17, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Carcinoma of right lung
 Due to Carcinoma of right Breast
 Due to _____

Other conditions
(Include pregnancy within 3 months of death)Major findings:
Of operations _____

Of autopsy _____

Duration

17 Mo.18 Mo.

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 injury)
(e) Means of injury _____23. Signature [Signature] (M. D. or other) _____
Address Poplar Bluff, Mo. Date signed 2/26/44

RECEIVED

District Health Office No. 2,

District File Number 344-495

Date Filed 3-14-44

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~~ 2-23-44

....., Registered Apprentice No.
working under my personal supervision.

Signed Philip A. Leuchel
Licensed Embalmer No. 2936
P. O. Address San Diego

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, fact should be so stated above.

STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 27 1944

Registration District No. 42

Primary Registration District No. 3007

Registrar's No. 72

1. PLACE OF DEATH:

(a) County Butler
(b) City or town.....
(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.....
(Specify whether
In this community.....
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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME

Eshe Moore

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

4. Sex..... 5. Color or race..... 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..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day 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: 2-29-44 (Month) (Day) (Year)

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

18. (a) Signature of funeral director Phil Leuchel
(b) Address Van Buren mo
19. (a) 3-10-44 (Date received local registrar) (b) Belle Turner (Registrar's signature)

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from..... 19.....
that I or saw him..... alive on..... 19.....
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..... (M. D. or other).....
Address..... Date signed.....

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

SUPPLEMENTARY

MOTHER FATHER

10513