No. 2
-8-43
17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 4 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

30960

State File No. .....

Registration District No. 206 Primary Registration District No. 3042 Registrar's No. 57

1. PLACE OF DEATH:

(a) County Madison

(b) City or town 713 South Wood Fredericktown
(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 ..... Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Madison 62

(c) City or town 713 South Wood 1
(If outside city or town limits, write "RURAL")

(d) Street No. Fredericktown 1
(If rural, give location)

(e) Citizen of foreign country? ✓ (Yes or No) 0

If yes, name country ✓

3. (a) PRINT FULL NAME Thompson Burbon Moore

3. (b) If veteran, name war ✓

3. (c) Social Security No. None

4. Sex Mo

5. Color or race W

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Laura Belle

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased May (Month) 15 (Day) 1865 (Year)

8. AGE:

Years	Months	Days	If less than one day
80	6	13	..... hr. ..... min.

9. Birthplace Madison (City, town, or county) 0 (State or foreign country)

10. Usual occupation Carpenter & Wood worker

11. Industry or business Self

FATHER
12. Name John Moore
13. Birthplace Tenn. (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Talitha Cumi
15. Birthplace Tenn. (City, town, or county) 1 (State or foreign country)

16. (a) Informant Cumi Moore

(b) Address Fredericktown Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/45 (Month) (Day) (Year)

(c) Place: burial or cremation Fredericktown Mo

18. (a) Signature of funeral director Webb & Holt

(b) Address Fredericktown Mo

19. (a) 9-20-1945 (Date received local registrar) (b) Florence Hicks (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Sept day 18 year 1945 hour 11:54 minute A M.

21. I hereby certify that I attended the deceased from May 1, 1945 to Sept 18, 1945 that I last saw him alive on 9-17, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Interstitial nephritis	1 yr
Due to	
Due to	
Other conditions Arteriosclerosis (Include pregnancy within 3 months of death)	
Major findings: Of operations Dilated heart	
Of autopsy	

131 N

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature M Henry Barron (M. D. ~~[illegible]~~)

Address Fredricktown Mo Date signed 9/19/45

1566 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 1045-1134

Date Filed 10-2-45

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 S. L. (Bill) Duncan, Registered Apprentice No. 390, working under my personal supervision.

Signed John S. Kelly

Licensed Embalmer No. 4264

P. O. Address Fredericktown, Ky.

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.

. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Oct

Registration District No. 206 Primary Registration District No. 3042 Registrar's No. 57

1. PLACE OF DEATH:

(a) County Madison

(b) City or town Fredericktown
(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 years, months or days)

In this community Life

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 Thompson B. Moore

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased May 15 1866
(Month) (Day) (Year)

8. AGE: Years 80 Months 6 Days 3 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day 8 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

30960