

S. No. 2
OM-543
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26342**

FILED AUG 27 1946

Registration District No. _____

Primary Registration District No. **1000**

Registrar's No. **942**

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **St Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1724 So. 10th /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community **Lifetime** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan** //
(c) City or town **St Joseph** /
(If outside city or town limits, write "RURAL")
(d) Street No. **1724 So. 10th** 7
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No?)
If yes, name country _____

3. (a) PRINT FULL NAME **Lillian Lee Moore**

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

4. Sex **Female** 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: **June 22 1946**
(Month) (Day) (Year)

8. AGE: Years **0** Months **1** Days **22** If less than one day hr. _____ min. _____

9. Birthplace **St. Joseph Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business _____

12. Name **James D. Moore**

13. Birthplace **St Joseph Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Lillian Jeffery**

15. Birthplace **Glascow Scotland**
(City, town, or county) (State or foreign country)

16. (a) Informant **James D. Moore**

(b) Address **St Joseph, Mo.**

17. (a) **Burial** (b) Date thereof **8-15-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cem.**

18. (a) Signature of funeral director **Fleeman & Son Inc.**
(b) Address **St Joseph, Mo.**

19. (a) **Aug. 22, 1946** (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **14**
year **1946** hour **1** minute **05** A. M.

21. I hereby certify that I attended the deceased from **8-9-46**, 19____ to **8-13-46**, 19____
that I last saw him **alive** on **8-13-46**, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death: **Congenital heart birth disease**

Due to _____

Due to _____

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

Major findings: **1572**
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 **H. Petersen** (M. D. or other) **MO**
Address **Kirkpatrick Bl, Wash** Date signed **8-14-46**

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

25188

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, ~~of~~ BY.....

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Robert H. Yapple

Licensed Embalmer No. 3308.....

P. O. Address. St Joseph, 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, fact should be so stated above.