V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 18 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20251
State File No.

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 212

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

1. PLACE OF DEATH:
(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No 1. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 years. 7 mo (Specify whether years, months or days)
In this community Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis 14
(c) City or town Robinson 1
(If outside city or town limits, write "RURAL")
(d) Street No. 2
(If rural, give location) 3
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME WOODSON MOORE.
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M 2
5. Color or race C
6. (a) Single, widowed, married, divorced W. 2
6. (b) Name of husband or wife D.K.
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 8 (Month) 5 (Day) 1866 (Year)
8. AGE: Years 80 Months 8 Days 1 If less than one day hr. min.
9. Birthplace Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Laborer.
11. Industry or business
MOTHER FATHER
12. Name D.K
13. Birthplace D.K (City, town, or county) 9 (State or foreign country)
14. Maiden name D.K
15. Birthplace D.K. (City, town, or county) 9 (State or foreign country)
16. (a) Informant Hospital Records
(b) Address Fulton Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 6 11 47 (Month) (Day) (Year)
(c) Place: burial or cremation Columbia Mo
18. (a) Signature of funeral director J. O. Roberts
(b) Address Columbia Mo
19. (a) 6-11-1947 (Date received local registrar) (b) Joan Mossuckhoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 6 year 1947 hour 3 minute 40 P.M.
21. I hereby certify that I attended the deceased from 6-1-47, 19__, to 6-6-47, 19__; that I last saw him alive on 6-6-47, 19__; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Hypostatic Pneumonia.
Dry gangrene right foot.
Due to Generalized Arteriosclerosis
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 B. P. Price (M. D. or other)
Address Fulton Mo Date signed 6/6/47
By H Price

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 6-17-47

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, fact should be so stated above.