

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16075

FILED MAY 19 1950

5161 State File No. 16075

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 387 PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. 12

1. PLACE OF DEATH a. COUNTY <i>Callaway</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Missouri</i> b. COUNTY <i>Callaway</i>	
b. CITY (If outside corporate limits, write RURAL and give township) <i>New Bloomfield Edin</i>		c. CITY (If outside corporate limits, write RURAL and give township) <i>New Bloomfield Mo 0140</i>	
c. LENGTH OF STAY (in this place) <i>11 months</i>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) <i>Mary</i> b. (Middle) <i>Alice</i> c. (Last) <i>Moore</i>			4. DATE OF DEATH (Month) (Day) (Year) <i>May 9 1950</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>Oct 28 - 1904</i>	9. AGE (In years last birthday) <i>45</i>	IF UNDER 1 YEAR Months <i>6</i> Days <i>15</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Colia Mo</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>					

13a. FATHER'S NAME <i>Richard Mabry</i>		13b. MOTHER'S MAIDEN NAME <i>Ellen Cohen</i>		14. NAME OF HUSBAND OR WIFE <i>Malcolm Moore</i>	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT'S SIGNATURE OR NAME, ADDRESS <i>Malcolm Moore New Bloomfield Mo</i>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hours</i>	
		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Arterio Sclerosis (fund)</i>			
		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<i>331X</i>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>May 9 1950 11:30 a.m.</i>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *May 8, 1950* to *May 9, 1950*, that I last saw the deceased alive on *May 9, 1950*, and that death occurred at *11:30 a.m.*, from the causes and on the date stated above.

23a. SIGNATURE <i>E. M. Rusk</i> (Type or title) <i>M.D.</i>		23b. ADDRESS <i>New Bloomfield Mo</i>		23c. DATE SIGNED <i>May 9 - 50</i>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		24b. DATE <i>May 11 - 50</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Oak Grove</i>	
				24d. LOCATION (City, town, or county) (State) <i>7 miles west Edin, Mo</i>	

DATE REC'D BY LOCAL REG. <i>May 10 - 50</i>		REGISTRAR'S SIGNATURE <i>LeRoy Claypool 39</i>		25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS <i>Colia Mo</i>	
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

140

District File Number  
District Health Officer No. 9,  
RECEIVED  
MAY 16 1950

JAN 31 1958

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 \_\_\_\_\_

working under my personal supervision. \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

Student .....  
Student Embalmer

Signed \_\_\_\_\_  
*Norman E. Good*

Licensed Embalmer No. 2342

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.  
*Not embalmed*