

Health,
Welfare
Public
Service

300
1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3997

STATE FILE NUMBER

FILED MAR 1 1957

Registration District No. 5-8 Primary Registration District No. 4089 Registrar's No. 4

| | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Carter</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ripley</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Grandin</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Doniphan</u> | | 0910 0 | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bell Rest Home</u> | | | Length of stay in 1b <u>10 days</u> | d. STREET ADDRESS (If outside, give location) <u>405 1st Street</u> | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>ARCHIBALD</u> Middle <u>YELL</u> Last <u>MOORE</u> | | | 4. DATE OF DEATH Month <u>Feb.</u> Day <u>11</u> Year <u>1957</u> | | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 20, 1876</u> | | 9. AGE (In years last birthday) <u>80</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Mercantile</u> | 11. BIRTHPLACE (City and state or country) <u>Ripley Co., Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>Samuel Moore</u> | | | 14. MOTHER'S MAIDEN NAME <u>Orlena Mathis</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | 17. INFORMANT Address <u>A. Y. Moore Jr. Doniphan, Mo</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: (a) _____ <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2-11-57</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>331x</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>0</u> | | | | | | |
| 20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY | STATE |
| 21. I attended the deceased from <u>1-7-56</u> to <u>2-11-57</u> and last saw her/him alive on <u>2-11-57</u> . Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Doctor or title) <u>Clifford DeForest M.D.</u> | | | | 22b. ADDRESS <u>Doniphan Mo</u> | | 22c. DATE SIGNED <u>2-11-57</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>2/13/1957</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Doniphan Centery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Doniphan, Missouri Mo</u> | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Edwards Funeral Home Doniphan, Mo</u> | | | 25. DATE RECD. BY LOCAL REG. <u>Feb. 26-1957</u> | | 26. REGISTRAR'S SIGNATURE <u>Mrs Octa Nelson</u> | | |

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

FEB 28 1957

CARTER COUNTY
HEALTH CENTER

MAR 4
1957

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 Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Gene H. Harris*
Licensed Embalmer No. *48*

P. O. Address *Abingdon*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.