

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004707

STATE FILE NUMBER

FILED FEB 16 1959

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 48

300  
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>CALLAWAY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Chariton</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>FULTON</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Keytesville</b> <u>0210</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR STATE HOSPITAL #1		Length of stay in 1b <b>2mos. 24das.</b>	d. STREET ADDRESS (If outside, give location) <b>Route 1</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>HOMER</b> Last <b>MOORE</b>			4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-21-1886</b>
9. AGE (In years last birthday) <b>73</b>		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) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William W. Moore</b>	
13b. MOTHER'S MAIDEN NAME <b>Elizabeth Langley</b>		14. NAME OF HUSBAND OR WIFE <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unk.</b>		16. SOCIAL SECURITY NO. <b>unk.</b>	17. INFORMANT Address <b>State Hospital No. 1; Fulton, Missouri</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY THROMBOSIS</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>GENERALIZED ARTERIOSCLEROSIS</b>			
DUE TO (c) <b>CHRONIC BRAIN SYNDROME WITH CIRCULATORY DISTURBANCE</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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>4261</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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. attended the deceased from <b>St. Hosp. #1</b> <u>11-18-1958</u> to <u>2-11-1959</u> Death occurred at <u>10:50 a.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>H. G. Fulmer M.D.</b>		22b. ADDRESS <b>State Hospital #1; Fulton, Mo.</b>	22c. DATE SIGNED <b>2-11-59</b>
23a. BURIAL, CREATION, or REMOVAL (Specify) <b>General</b>	23b. DATE <b>Feb 13, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Marcelline</b>	23d. LOCATION (City, town, or county) (State) <b>Mo.</b>
24. FUNERAL DIRECTOR <b>Marjorie General Home</b>		25. DATE RECD. BY LOCAL REG. <b>Feb. 13-1959</b>	26. REGISTRAR'S SIGNATURE <b>Marjette Lawrence</b>

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 *Marshall C. Blackwell*

Licensed Embalmer No. *4713*

P. O. Address *Fulton, m*

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