

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010627
STATE FILE NUMBER

LED MAR 24 1959 Registration District No. 316 Primary Registration District No. 3060 Registrar's No. 111

300
1-57

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Francois	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Farmington		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Farmington 0940
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 502 N. Jackson
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Martin Tolman Moore			4. DATE OF DEATH Month Day Year March 14 1959		
---	--	--	---	--	--

5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1882	9. AGE (In years last birthday) 76	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) Retired Hospital Attendant	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Francois Co., Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	-----------------------------------	---	--

13a. FATHER'S NAME Riley Moore	13b. MOTHER'S MAIDEN NAME Mary Elizabeth McFarland	14. NAME OF HUSBAND OR WIFE Pearl Moore
-----------------------------------	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, [?], unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 498-34-2154	17. INFORMANT Pearl Moore	Address Farmington, Missouri
---	--	------------------------------	---------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 5 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Anterior-cerebral heart disease	6 yrs.
	DUE TO (c)	
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.) 4200
---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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 March 1958 to 3-14-59 and last saw him alive on 1-20-59 Death occurred at 5 PM m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) C. E. Carleton, M.D.	22b. ADDRESS Farmington Mo	22c. DATE SIGNED 3-16-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/17/59	23c. NAME OF CEMETERY OR CREMATORY Bonne Terre Cemetery	23d. LOCATION (City, town, or country) (State) Bonne Terre Missouri
---	----------------------	--	--

24. FUNERAL DIRECTOR Miller Funeral Home	ADDRESS Farmington, Mo.	25. DATE RECD. BY LOCAL REG. Mar. 17, 1959	26. REGISTRAR'S SIGNATURE Catherine Rudloff
---	----------------------------	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Bert J. Miller*
Licensed Embalmer No. *3752*
P. O. Address *Farmington,*

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.