

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=60-016152**

**FILED VS APR 27 1960**

209 Primary Registration District No. 3043 Registrar's No. 145

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MARION</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HANNIBAL</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A. LEVERING Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MARION</u> c. CITY OR TOWN <u>HANNIBAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>705 So. MAIN</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>MINNIE SUSAN MOORE</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>4-16-1960</u>									
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>4-17-1884</u>		<b>9. AGE (last birthday)</b> <u>75</u>		<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HR</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (City and state or country) <u>PARIS MO</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U. S. A.</u>			
<b>13a. FATHER'S NAME</b> <u>William JENKINS</u>				<b>13b. MOTHER'S MAIDEN NAME</b> <u>MARY FRANCES WHITAKER</u>				<b>14. NAME OF HUSBAND OR WIFE</b> <u>ALBERT W. MOORE</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> Address <u>Mrs. MYRTLE MAE JONES R2, PANOLA MO</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Coronary sclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Peristent bronchite.</u>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT SUICIDE HOMICIDE</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year <u>4 16 60</u>		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>			
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>7:40 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
<b>22a. SIGNATURE</b> (Degree or title) <u>Lenny H Sweet Jr Coroner</u>						<b>22b. ADDRESS</b> <u>Hannibal Mo</u>			<b>22c. DATE SIGNED</b> <u>4/16/60</u>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE</b> <u>4-19-1960</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>MT OLIVET CEMETERY</u>			<b>23d. LOCATION</b> (City, town, or county) (State) <u>HANNIBAL, MISSOURI</u>						
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>H.M. O'DONNELL, Hannibal, Mo</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>4/21/60</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Dr. E.M. Lucke by Lillian M. Herman</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

2100

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed JM O'Donnell

Licensed Embalmer No. 3889

P. O. Address Hannibal, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.