

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-019081

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 354

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAY 23 1963

1. PLACE OF DEATH
a. COUNTY *Boone County*
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN *Columbia* Length of stay in 1b *11 days*
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION *Boone County Hospital* Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE *Mo* b. COUNTY *Randolph*
c. CITY OR TOWN *Higbee* Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) *Route* Reside on Farm Yes No

3. NAME OF DECEASED First *Ida* Middle *May* Last *Moore*
4. DATE OF DEATH Month *May* Day *19* Year *1963*

5. SEX *Female* 6. COLOR OR RACE *white* 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH *Nov. 31 1894* 9. AGE (last birthday) *68* IF UNDER 1 YEAR Months *6* Days *16* IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Housewife* 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) *Higbee Mo.* 12. CITIZEN OF WHAT COUNTRY *U.S.A.*

13a. FATHER'S NAME *George H. Cartow* 13b. MOTHER'S MAIDEN NAME *Hannah Carter* 14. NAME OF HUSBAND OR WIFE *Maurice C. Moore*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes; no, or unknown) (If yes, give war or dates of 16. SOCIAL SECURITY NO. 17. INFORMANT *Daughter Beatrice Whitake Madison, Mo* Address *Route #*

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Adeno Carcinoma, Breast,*
DUE TO (b) *with generalized metastases* INTERVAL BETWEEN ONSET AND DEATH *6 mos.*
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____
PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour _____ Month, Day, Year. _____ a.m. _____ p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 *3-1-63* to *5-19-63* and last saw her/him alive on *5-19-63*
Death occurred at *4:15 PM* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) *E. E. Sheward M.D.* 22b. ADDRESS *1502 E Broadway* 22c. DATE SIGNED *5-19-63*

23a. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 23b. DATE *May 21, 63* 23c. NAME OF GEMETERY OR CREMATORY *Higbee* 23d. LOCATION (City, town, or county) (State) *Higbee MO*

24. FUNERAL DIRECTOR *Million & Green* ADDRESS *Mo* 25. DATE RECD. BY LOCAL REG. *May 19 1963* 26. REGISTRAR'S SIGNATURE *Mrs R.E. Palmer*

USE BLACK INK OR TYPEWRITER RIBBON

EBB 27 1964

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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 _____

Licensed Embalmer No. _____

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