

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

B. N. 1725

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
 Township Kane Primary Registration District No. 1002  
 City N. C. Mo. (No. Grace Hospital)

File No. 317  
 Registered No. 317  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Martin L. Moad  
 (a) Residence. No. 1720 Park, ave St. 11 Ward. \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred  
 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Margaret J. Moad

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May-1-1850

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
78 | 8 | 20

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Farmer  
 (b) General nature of industry, business, or establishment in which employed (or employer) Retired  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Calvin Moad

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Tenn

12. MAIDEN NAME OF MOTHER Mary Paulay

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Tenn

14. INFORMANT J. F. Moad (Address) Liberty, Mo, R.F.D. #2

15. FILED 122 29 19 29 M. M. Louie REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 16, 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1929, to Jan 21, 1929, that I last saw him alive on Jan 20, 1929, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
1929 Hypertensive bleed Prostate

CONTRIBUTORY Uræmia (SECONDARY) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED 1515 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

IF NOT AT PLACE OF DEATH, DID AN OPERATION PRECEDE DEATH? Yes DATE OF Jan 18

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) Julius Fischer M. D. (Address) 337 Lathrop Bldg

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL California, Mo DATE OF BURIAL Jan 22, 1929

20. UNDERTAKER Mrs. C. L. Forster ADDRESS N. C. Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

