

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.

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

Do not use this space.

REB 2 0 1935

640

1. PLACE OF DEATH

County Cole  
Township Jefferson  
City Jefferson

Registration District No. 213  
Primary Registration District No. 3014

File No. 640  
Registered No. 43  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

(a) Residence, No. 411 Madison St., \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (If nonresident, give city or town and State)

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 Julia white  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 13 - 1867  
7. AGE YEARS 67 MONTHS 3 DAYS 13 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Retired  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Massachusetts

13. NAME Donald Moore

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mass

15. MAIDEN NAME Dorah Gray

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mass

17. INFORMANT (ADDRESS) Erie Moore  
411 Madison

18. BURIAL, CREMATION, OR REMOVAL PLACE High Point DAY Jan 28 35

19. UNDERTAKER (ADDRESS) Lawson - Harrison  
Jefferson

20. FILED 1/30/1935 Dr. Russell M. O. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 27 35

22. I HEREBY CERTIFY, That I attended deceased from 2 did not attend deceased  
I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_, m.  
The principal cause of death and related causes of importance were as follows:  
Acute Appoplexy

Other contributory causes of importance: 1

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify \_\_\_\_\_

(Signed) Dr. R. E. W. or Co. 202  
(Address) Russell M. O.

