...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

PLACE OF DEATH

County Pemiscot

Township ______ or Village Steele, Mo or City ______ (NO. ______ St.; ______ Ward)

Registration District No. 655

Primary Registration District No. 4392

File No. 32216

Registered No. 18

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Floyd Moore

PERSONAL AND STATISTICAL PARTICULARS	
SEX	Male
COLOR OR RACE	White
SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)	
DATE OF BIRTH	May (Month) 3rd (Day), 1911 (Year)
AGE	— yrs. 4 mos. 10 ds. If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work	None
(b) General nature of industry, business, or establishment in which employed (or employer)	
BIRTHPLACE (City or town, State or foreign country)	Steele Mo
PARENTS — NAME OF FATHER	J. L. Moore
BIRTHPLACE OF FATHER (City or town, State or foreign country)	Tenn.
MAIDEN NAME OF MOTHER	Lillie Young
BIRTHPLACE OF MOTHER (City or town, State or foreign country)	Steele Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J L Moore

(ADDRESS) Steele, Mo

Filed Sep 20th 1911 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. (Month) 14th (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 1st, 1911, to Sept 14th, 1911, that I last saw him alive on Sept 13th, 1911, and that death occurred, on the date stated above, at 4 a.m. The CAUSE OF DEATH* was as follows:

Gastro Enteritis

119B 104

(Duration) ___ yrs. ___ mos. 14 ds.

Contributory (SECONDARY) Mothers ill health

(Duration) — yrs. 2 mos. ___ ds.

(Signed) W. A. Swearingen M. D.

9/17, 1911 (Address) Steele Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? ______

Former or usual residence ______

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fowlkes Graveyard	Sept 15, 1911
UNDERTAKER	ADDRESS
C. B. Howard	Steele, Mo

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

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____, 1_____
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS

NAME OF FATHER _____

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 191____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) ____ yrs. ____ mos. ____ ds.

Contributory _____
(SECONDARY)

_____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.