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

PLACE OF DEATH

County: Shelby

Township or Village or City: Black Creek

Registration District No. 831 — File No. 33248

Primary Registration District No. 6092 — Registered No. 26

(NO. ____ St.: ____ Ward)

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

FULL NAME: ~~Alice~~ Arlene Moss

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: Feb. 11, 1916 (Month) (Day) (Year)

AGE: ____ yrs. 7 mos. 4 ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work: X
(b) General nature of industry, business, or establishment in which employed (or employer): X

BIRTHPLACE (City or town, State or foreign country): Shelby Co. Mo.

PARENTS

NAME OF FATHER: Walter Moss

BIRTHPLACE OF FATHER (City or town, State or foreign country): Shelby Co.

MAIDEN NAME OF MOTHER: Ruby Lee Taylor

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Shelby Co.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Walter Moss

(ADDRESS): Shelbyville Mo.

Filed Sept 15, 1916 Wm Carson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept. 15, 1916 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept. 11, 1916, to Sept. 15, 1916, that I last saw her alive on Sept. 15, 1916, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ____ yrs. ____ mos. 10 ds.

Contributory (SECONDARY) ____

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

(Signed) Dr. W. T. Patterson M. D.

Sept 15, 1916 (Address) Oak Dale

*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: Shelbyville I.O.O.F.

DATE OF BURIAL: Sept. 16, 1916

UNDERTAKER: J. W. Thompson Son

ADDRESS: Shelbyville Mo.

Statement of cause of death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is Medical Association.)

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

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

or

City _____ (NO. _____ St.: _____ Ward)

FULL NAME _____

MISSOURI STATE BOARD OF
BUREAU OF VITAL STATIST
CERTIFICATE OF DEATH

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

_____
(Month)

I HEREBY CERTIFY, that I attended de

_____, 191__, to _____

that I last saw h_____ alive on _____

and that death occurred, on the date stated above, a

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mos.

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos.

(Signed) _____

_____, 191__ (Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN RECENT RESIDENTS)

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

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURI
UNDERTAKER	ADDRESS

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F VITAL STATISTICS
IFICATE OF DEATH

No. _____

istered No. _____

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[If death occ hospital or give its NAM of street and

IFICATE OF DEATH

_____, 19
nth) (Day)

FY, that I attended decea

to _____, 1

_____, 1

date stated above, at _____

as follows:

_____ yrs. _____ mos.

_____ yrs. _____ mos.

s) _____

or, in deaths from Violent Ca
Accidental, Suicidal or Ho

spitals, Institutions, Tr

In the State _____ yrs. _____ mos.

DATE OF BURIAL
ADDRESS