N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. [illegible] 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

PLACE OF DEATH

County Buchanan

Township _____ Registration District No. 85 File No. 36819

or

Village _____ Primary Registration District No. 1001 Registered No. 1150

or

City Saint Joseph (NO. Saint Joseph hospital St.; _____ Ward)

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

FULL NAME Mary Francis Moore

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED X WIDOWED OR DIVORCED (Write the word)
Female	White	married

DATE OF BIRTH 5 (Month) 24 (Day), 1868 (Year)

AGE 48 yrs. 5 mos. 13 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

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

PARENTS
NAME OF FATHER Thomas Beam
BIRTHPLACE OF FATHER (City or town, State or foreign country) Georgia
MAIDEN NAME OF MOTHER Emily Brown
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Georgia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emily Beam

(ADDRESS) Agency Mo.

Filed Nov. 9, 1916, D. O. Kelly REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH November (Month) 7 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from November 2nd, 1916, to November 7th, 1916, that I last saw her alive on November 6th, 1916, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Inversion of Uterus (chronic)

130 13 36

(Duration) 3 yrs. 0 mos. 0 ds.

Contributory (SECONDARY) hemorrhage and sepsis

(Duration) 3 yrs. 0 mos. 0 ds.

(Signed) S. E. Meluney M. D.

Nov. 9th, 1916 (Address) Agency 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 0 yrs. 0 mos. 2 ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? Agency Mo.

Former or usual residence Agency Mo

PLACE OF BURIAL OR REMOVAL Agency Mo

DATE OF BURIAL Nov. 9, 1916

UNDERTAKER H. A. Sullins

ADDRESS Agency Mo.

PLACE OF DEATH

County _____

Township _____
or
Village _____
or
City _____ (NO. _____, _____ St.: _____ Ward)

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[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 _____ (Month) _____ (Day), 1_____ (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) _____ (Day), 191____ (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, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state it so that it may be properly classified. Exact statement of OCCUPATION is very important.