

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

Do not use this space.

1. PLACE OF DEATH

County Madison
Township Castor
City Reva Francis Moore (No. _____) St. _____ Ward _____

Registration District No. 537
Primary Registration District No. 5727

File No. 27780
Registered No. _____

2. FULL NAME

Reva Francis Moore
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr-23-1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____hra. or _____min.
— 3 — 2

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Madison Co. Missouri
(STATE OR COUNTRY)

10. NAME OF FATHER Wm H. Moore

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Lee Run Missouri
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mada Jansen

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Lee Run Missouri
(STATE OR COUNTRY)

14. INFORMANT W. H. Moore
(Address) Fredericktown Mo.

15. FILED 9 1927 C. H. Davis M.D. REGISTRAR
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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 27 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 12, 1927 to Sept 27, 1927
that I last saw h. alive on Sept 27, 1927, and that death occurred, on the date stated above, at 10:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute dysentery
13c
118c (duration) _____ yrs. _____ mos. 16 ds.
CONTRIBUTORY Chronic indigestion
(SECONDARY) (duration) 3 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) S. Slaughter, M. D.

*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 Fredericktown DATE OF BURIAL 9/29 1927

20. UNDERTAKER Ed. H. Webb ADDRESS Fredericktown Mo.

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.

10/10/10