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.

1 28 1921

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

Do not use this space.

31339

1. PLACE OF DEATH

County St Francois — Registration District No. 779 — File No.

Township Randolph — Primary Registration District No. 6024a — Registered No.

City ~~Desloge~~ (No. ..... St. ..... Ward)

2. FULL NAME Opal Golden Moyer

(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): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Oral R. Moyer

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct. 12, 1900

7. AGE: Years 26 — Months 11 — Days 25 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Goodland Mo

PARENTS

10. NAME OF FATHER: Mounce Anderson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Tennessee
12. MAIDEN NAME OF MOTHER: Josephine Reed
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Missouri

14. INFORMANT: Oral Moyer
(Address) Desloge Mo.

15. FILED 10-14, 1927 R. B. Lester, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct 12 1927

17. I HEREBY CERTIFY, That I attended deceased from May 2nd, 1927, to Oct 12, 1927, that I last saw her alive on Oct 12, 1927, and that death occurred, on the date stated above, at 4:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
23A
(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 31
(duration) ..... 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) F. A. Elders, M. D.
10-14-, 1927 (Address) Desloge Mo

*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: Parkview Cemetry — DATE OF BURIAL: Oct. 14 1927

20. UNDERTAKER: C. Z. Boyer — ADDRESS: Desloge Mo