

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

Do not use this space.

36312

1. PLACE OF DEATH

County Clay
Township Platte
City (No. _____) St. _____ Ward _____

Registration District No. 203
Primary Registration District No. 5281

File No. _____
Registered No. _____

2. FULL NAME

Nancy Katherine 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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 23 - 1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
73 | 10 | 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Keeper
(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) Clay Co Mo

10. NAME OF FATHER Hard Hard

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Patsy Ann Baily

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Virginia

14. INFORMANT (Address) Shelby Moore
Trifable, Mo

15. FILED 1/10, 1928 E. C. Hill REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec-9-1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 24, 1915, to Dec 9, 1927 that I last saw him alive on Dec 9, 1927, and that death occurred, on the date stated above, at 7-0 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diabetes Mellitus

59 57

(duration) 12 yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY)

(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) J. F. Rupp, M. D.

(Address) Smithville Mo. R#2

*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 DATE OF BURIAL

Paradise Cem Dec-11-1927

20. UNDERTAKER ADDRESS

J. H. Rollins Edgerton Mo

All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

17 1928

