

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

Do not use this space.

30432

**1. PLACE OF DEATH**

County Jackson

Registration District No. 399

Township Shaw

Primary Registration District No. 16.6.2

City Fancus City (No. 507)

Street St. Peter

File No. 3070

Registered No. 3070

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Kay Moore

(a) Residence. No. 507 St. Peter St. 5 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

M

**4. COLOR OR RACE**

Col.

**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)**

Jan. 22, 1887

**7. AGE**

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>41</u>	<u>9</u>	<u>12</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Laborer  
 (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) Missouri

**10. NAME OF FATHER**

Jno. Moore

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Mo.

**12. MAIDEN NAME OF MOTHER**

Martha Freeman

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Mo.

**14. INFORMANT**

Martha Moore

(Address) 507 St. Peter

**15. FILED**

9/5, 28 M. M. Brewer  
Usor REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

9/4 1928

**17.**

I HEREBY CERTIFY, That I attended deceased from January, 1928, to Sept. 9, 1928.  
 That I last saw him alive on Sept. 7, 1928, and that death occurred, on the date stated above, at 11:30 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

pulmonary tuberculosis

**CONTRIBUTORY (SECONDARY)**

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

① DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical - laboratory

(Signed) Jesse R. Haley, M. D.

(Address) 1002 medical arts Bldg.

\*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**

Highland

**DATE OF BURIAL**

9/6 1928

**20. UNDERTAKER**

Hickins Bros

**ADDRESS**

1729 Lyda

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.

Dr. Healy  
802 Medwest  
C. B. Building