

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

Do not use this space.

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 36950
 Township Old City City Registration District No. 1002 Registered No. 1599
 City H. C. No. Old City Hospital St. _____ Ward _____

2. FULL NAME

Edward Moore
 (a) Residence No. 2006 E. 19th St. 12 Ward _____
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 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) Aug. 15, 1918

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
10 2 2

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Texas
 (STATE OR COUNTRY)

10. NAME OF FATHER Infeld Moore

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

12. MAIDEN NAME OF MOTHER Toma Walker

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

14. INFORMANT mother
 (Address) 2006 E. 19th

15. FILED 11/15/28 M. M. Krowe REGISTRAR
Assn

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/17 28

17. I HEREBY CERTIFY That I attended deceased from 11/17 1928, to 11/17 1928
 that I last saw him live on 11/17 1928, and that death occurred, on the date stated above, at 11:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart Failure
9:21 a.m.
 (duration) _____ yrs. mos. da.
 CONTRIBUTORY mit insufficiency
 (SECONDARY) (duration) _____ mos. da.

18. WHEN WAS DISEASE CONTRASTED

NOT AT PLACE OF DEATH. no
 DID AN OPERATION PRECEDE DEATH. no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? no

(Signed) H. M. Smith M. D.
11/13, 1928 (Address) Old City Hosp

*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 Blue Ridge Lawn DATE OF BURIAL 11/15/28

20. UNDERTAKER Hatkins & Bros. ADDRESS 1729 Lydia

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

K. 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.

