

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.

*Roddes*

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

Do not use this space.

39125

**1. PLACE OF DEATH**

County *Leas*  
Township *Rushland*  
City (No. ) (Ward)

Registration District No. *82/*  
Primary Registration District No. *6070*

File No. *91*  
Registered No. \_\_\_\_\_

**2. FULL NAME**

*Dory Marie*

(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 *Male* | 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 \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Apr 13 1897*

| 7. AGE    | YEARS    | MONTHS    | DAYS | IF LESS than 1 day, _____hra. or _____min. |
|-----------|----------|-----------|------|--|
| <i>27</i> | <i>7</i> | <i>13</i> |      |  |

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

9. BIRTHPLACE (CITY OR TOWN) *Perry Co*  
(STATE OR COUNTRY) *Mo*

10. NAME OF FATHER *Frank Moore*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Perry Co*  
(STATE OR COUNTRY) *Mo*

12. MAIDEN NAME OF MOTHER *Ludmilla Jucka*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Perry Co*  
(STATE OR COUNTRY) *Mo*

14. INFORMANT *Mary Marie*  
(Address) *St. Joseph Mo*

15. FILED *11/10/28* *Walter Edens*  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov 26 1928*

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at *5:30 a* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Apoplexy following attack of acute Endocarditis*  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) *HT*  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED *at home*  
IF NOT AT PLACE OF DEATH: \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? *no* DATE OF *Nov 26-28*

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *none*

(Signed) *R. O. Roddes, M. D.* 19 *28* (Address) *St. Joseph Mo*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MANNER AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *St. Joseph* DATE OF BURIAL *11/21 1928*

20. UNDERTAKER *W. J. Welch* ADDRESS *St. Joseph Mo*

