

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

Do not use this space.

1820

1. PLACE OF DEATH

County Jackson
Township Kaw
City K.C. Mo.

Registration District No. 399
Primary Registration District No. 1002
(No. 4346 Montgall)

File No. 412
Registered No. 412
St. 16 Ward 1

2. FULL NAME

Thomas LaVergne Moor
(a) Residence. No. 4346 Montgall St. 16 Ward 1

(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 Male 4. COLOR OR RACE Wh 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) Nov 11th 1928

7. AGE: YEARS MONTHS DAYS IF LESS than 1 day, ____ hrs. or ____ min.
2 15 —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child
(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) Kansas

10. NAME OF FATHER

Thomas F. Moor

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Kansas

12. MAIDEN NAME OF MOTHER

Ella Kirby

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Ill.

14.

INFORMANT Thomas F. Moor
(Address) 4346 Montgall K.C. Mo

15.

FILED 1-27-29 M. M. Brown REGISTRAR
Boat

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 26 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 25, 1929, to Jan 26, 1929, that I last saw him alive on Jan 26, 1929, and that death occurred, on the date stated above, at 10:10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia

107A

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____

WAS THERE AN AUTOPSY: _____

WHAT TEST CONFIRMED DEATH? _____

(Signed) E. H. Hynes, M. D.

127, 1929 (Address) St. + 2nd St

*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

Humboldt Kansas

1/27 1929

20. UNDERTAKER

ADDRESS

W. F. Mayberry Kan City Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated in years, months and days. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County.....
Township.....
City St. City (No.....)

Registration District No. 399
Primary Registration District No. 1002

File No.....
Registered No. 412
St. Ward)

2. FULL NAME

(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 m 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work.....
(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT.....
(Address)

15.

FILED 1/27 19 29 M. M. Brown
asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 26 1929

17.

I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19.....

that I last saw h..... after on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bacterial pneumonia
(Primary)
(duration) yrs. mos. ds.

CONTRIBUTORY
(SECONDARY)

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)....., M. D.
, 19 (Address)

*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

20. UNDERTAKER

ADDRESS

19

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES IF THEY ARE COMPLETE AS PRESCRIBED BY LAW
information should be carefully DEATH in plain terms, so that it may be F
do stated EXACTLY. HUMAN should state act statement THE INFORMATION is very

S-1820