MAR 27 1929

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

Do not use this space.

6313

1. PLACE OF DEATH

County: Iron — Registration District No. 6 393 — File No.

Township: 34 Dent — Primary Registration District No. 65548 — Registered No. 3

City: Black — (No. 1 B57 Iron Co St. Mo. Ward)

2. FULL NAME Thelmia Lorean Moore

(a) Residence. No. ..... St., Mo. Ward. (If nonresident give city or town and State)
(Usual place of abode)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	

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.
	2	11	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: [illegible]
(b) General nature of industry, business, or establishment in which employed (or employer): Pincer
(c) Name of employer: Round Spring

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Reynolds Co

PARENTS

10. NAME OF FATHER: G. W. Moore
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Reynolds Co
12. MAIDEN NAME OF MOTHER: Mary Alice
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Reynolds Co

14. INFORMANT: Milley Wolf
(Address): Black Mo

15. FILED ....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb 25 1929

17. I HEREBY CERTIFY, That I attended deceased from 2-12, 1929, to 2-24, 1929, that I last saw her alive on 2-15, 1929, and that death occurred, on the date stated above, at 12-35 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mastoid Trouble
29R
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 860
(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) F E Stafford, M.D
, 19 (Address) Bixby Mo

*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. Natural

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL: 3/21 1926

20. UNDERTAKER: Alfred Hedgecoth — ADDRESS

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: Pon — Registration District No.: 393 — File No.:

Township: Dent — Primary Registration District No.: 3548 — Registered No.: 3

City: ..... (No. ..... St. ..... Ward)

2. FULL NAME: Thelsinia Lucean 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: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Mar 22 — 1926

7. AGE: Years 2 — Months 11 — Days 3 — 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)

PARENTS

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 Apr 8, 1929 Belle Pipkin
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb 25 1929

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 ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) ..... 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) ....., 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: Westfall Cemetery — DATE OF BURIAL: 3/21 19[illegible]

20. UNDERTAKER: Alf Hedgcath — ADDRESS: Bixby Mo

SUPPLEMENTARY

SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LA

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