

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

Do not use this space.

1. PLACE OF DEATH

County Ruchanan
Township _____
City St. Joseph, (No. 1114 Olive)

Registration District No. 85
Primary Registration District No. 1001

File No. 9609
Registered No. 314
St. _____ Ward)

2. FULL NAME Ira M. Moore,

(a) Residence. No. 1114 Olive St., _____ Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 80 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 Mattie Moore,

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 28, 1839

7. AGE	YEARS	MONTHS	DAY	If LESS than 1 day, _____ hrs. or _____ min.
	<u>89</u>	<u>7</u>	<u>8</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Mariotta,
(STATE OR COUNTRY) Ohio,

10. NAME OF FATHER Abirhan Moore,

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

12. MAIDEN NAME OF MOTHER Rachel Moore

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

14. INFORMANT J. F. Endebracht

Address) 1114 Olive Street,

15. FILED John G. [Signature] REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 6 1929

17. I HEREBY CERTIFY, That I attended deceased from 5 P.M. 15, 1929, to March 6, 1929 that I last saw alive on March 4, 1929, and that death occurred, on the date stated above, at 8:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arterio-sclerosis

CONTRIBUTORY (SECONDARY) Inherited Hypertension
(duration) 1 yrs. 1 mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED 129a
IF NOT AT PLACE OF DEATH _____
(duration) _____ yrs. _____ mos. _____ ds.

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) London D. [Signature], M. D.
March 8, 1929 (Address) 845 So. 11th St. St. Joe, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Highland Cemetery DATE OF BURIAL March 8th, 1929

20. UNDERTAKER Heaton, B. Gale & Bowers ADDRESS 319 S. 10 St.

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.

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MAR 8 1929

Funeral Home

