

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

Do not use this space.

30038

1. PLACE OF DEATH
 County Benton Registration District No. 6697 File No. 1
 Township Lindsay Primary Registration District No. 5097 Registered No. 26
 City Warsaw (No.) St. Ward)

2. FULL NAME Elizabeth Closer Moor
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 28 1841
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
88 6 7

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

9. BIRTHPLACE (CITY OR TOWN) Winnis
 (STATE OR COUNTRY) Switzerland

10. NAME OF FATHER Christian Closer

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

12. MAIDEN NAME OF MOTHER Knaut's

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

14. INFORMANT Mrs. Wm. Mastr
 (Address) Warsaw Mo

15. FILED 9/11 1929 Jas A Logan
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 4 1929
 17. I HEREBY CERTIFY, That I attended deceased from Dec 12 1926, to Feb 1927, that I last saw him alive on May 18 1927, and that death occurred, on the date stated above, at 1:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mucous Toxaemia

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH,
 (duration) 2 yrs. 6 mos. da.

CONTRIBUTORY (SECONDARY)
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH,
 DID AN OPERATION PRECEDE DEATH? no DATE OF
 WAS THERE AN AUTOPSY?

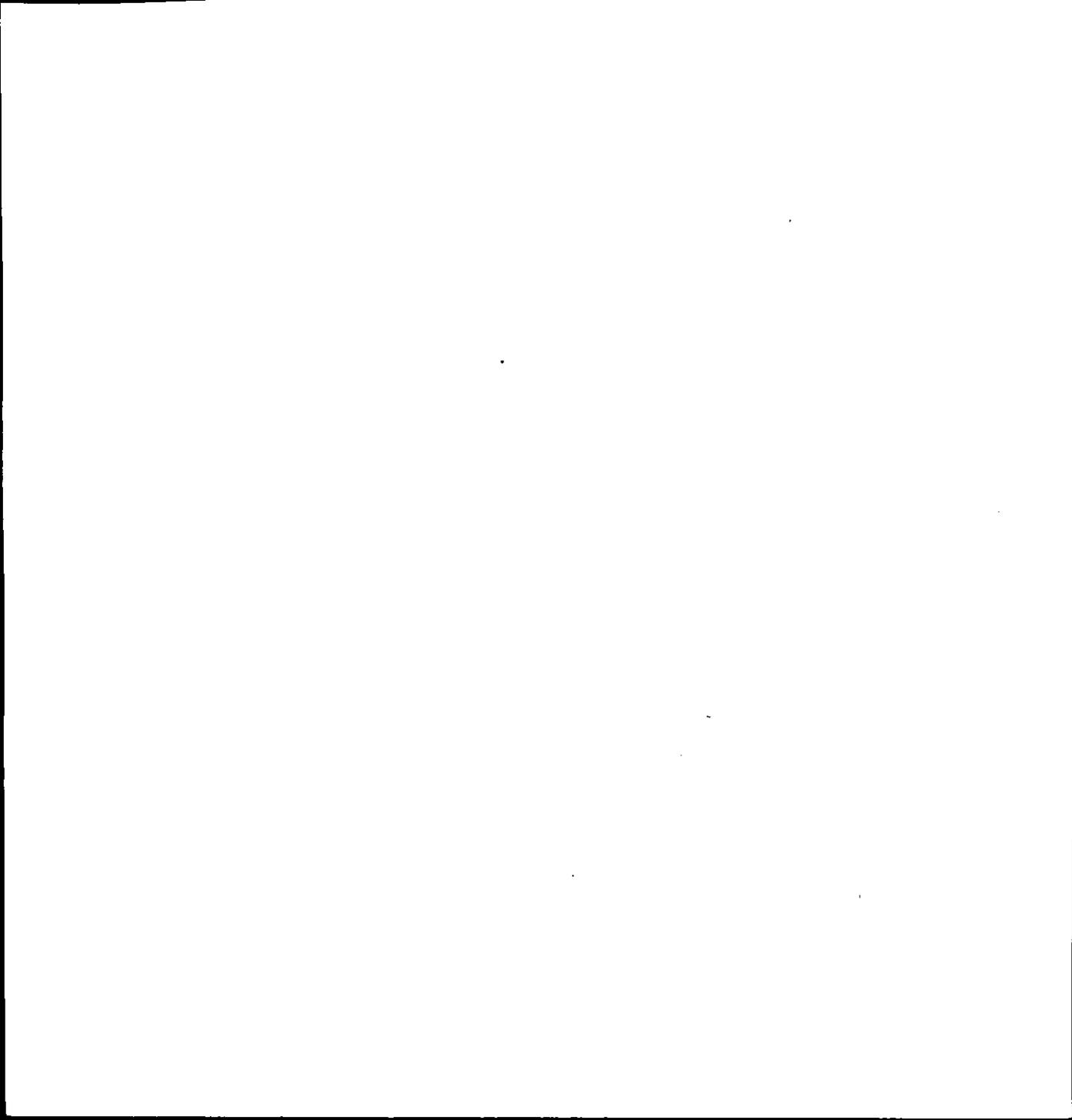
WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) S. O. Stouten, M. D.
9/4, 1929 (Address) Lincoln

*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 St. Paul's Pleasant Care DATE OF BURIAL Sep 5 1929

20. UNDERTAKER J. B. Calvert, Lincoln Mo. ADDRESS

PARENTS



**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 Denton
Township Lindsay
City Elizabeth (No. 0)

Registration District No. 61
Primary Registration District No. 3099

File No. _____
Registered No. 26
St. _____ Ward) _____

2. FULL NAME

Elizabeth O. Moor

(a) Residence. No. _____ St. _____ Ward. _____
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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 9/30/24 Jas A Logan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 4 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:

Chronic Interstitial Nephritis
(duration) _____ yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 290
(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 _____	DATE OF BURIAL _____
	19 _____

20. UNDERTAKER _____	ADDRESS _____
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SUPPLEMENTARY

S-36038