

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

Do not use this space.

36375

1. PLACE OF DEATH 85  
 County Buchanan Registration District No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 1001  
 City St. Joseph (No. St. Joseph Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Ann Moran  
 (a) Residence. No. Catholic Orphanage 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.

File No. 1299  
 Registered No. \_\_\_\_\_  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 4, 1853

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
78 4 6

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Seamstress  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer Catholic Orphanage

9. BIRTHPLACE (CITY OR TOWN) Alton  
 (STATE OR COUNTRY) Ill.

10. NAME OF FATHER Barney Moran  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown  
 (STATE OR COUNTRY) Ireland  
 12. MAIDEN NAME OF MOTHER Ann Lynch  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown  
 (STATE OR COUNTRY) Ireland

14. INFORMANT Mrs. Kate M Mackay  
 (Address) St. Joseph Mo.

15. FILED Nov 11 1929 John E. [Signature] REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) November 10 1929

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 1929 to \_\_\_\_\_, 1929 that I last saw h. ST alive on \_\_\_\_\_, 1929 and that death occurred, on the date stated above, at 7/15 P m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Robert [Signature]  
10B / 10 / 10  
 \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 6 ds.

CONTRIBUTORY (SECONDARY) None  
 \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? Yes DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? Yes  
 WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_  
 (Signed) [Signature], M. D.  
Nov. 11, 1929 (Address) St. Joseph 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 Mt Olivet Cemetary DATE OF BURIAL Nov. 12 1929

20. UNDERTAKER A.C. Sidenfaden ADDRESS 1802 Union St

WHITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

K. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

56 18 1929

