

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

Do not use this space.

**39581**

**PLACE OF DEATH**

County Madison  
Township Paterson  
City Waver (No. 909 S. Westoveral)

Registration District No. 26  
Primary Registration District No. 3002

File No. \_\_\_\_\_  
Registered No. 166 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Mary C. Moore  
(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 4 - 1889

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
80 3 12

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Bushon Co  
(STATE OR COUNTRY) Ind

10. NAME OF FATHER Walter Stewart

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Ed F. Moore  
(Address) Waver Mo

15. Dec 16th 1929 FILED Geo S Milligan REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec-15-1929

17. I HEREBY CERTIFY That I attended deceased from March 1928, to Dec-15 1929 that I last saw her alive on Dec 14 1929, and that death occurred, on the date stated above, at 11:35 A.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Senescence of old age -  
Complication of disease -  
Pneumonia & Complications yrs. mos. da. 3.0

CONTRIBUTORY Paralysis  
32. (SECONDARY) 16 JA (duration) yrs. mos. da. 16 3

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS: \_\_\_\_\_

(Signed) R. H. Van Hyngorden, M. D.  
, 19 (Address) Waver 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 DATE OF BURIAL

Waver Mo. Cem 12-17-1929

20. UNDERTAKER ADDRESS

H. J. Pickett & Son Waver Mo.

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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**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 BIRTH

County Audrain  
Township.....  
City Mexico (No. ....) St. .... Ward.....

Registration District No. 26  
Primary Registration District No. 3002

File No. ....  
Registered No. 166  
St. .... Ward.....

2. FULL NAME

Mary C. 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 ..... 4. COLOR OR RACE ..... 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (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. Dec 16th 1929 Ira S. Milligan REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 15-1929

17. I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19..... that I last saw him ..... alive on ..... 19..... and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Pneumonia  
(duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) Complication of disease  
Mesenteria (duration) .... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED Gift stroke of paralysis  
IF NOT AT PLACE OF DEATH, about a year ago  
DID AN OPERATION PRECEDE DEATH? but the name recovered DATE OF .....

19. WAS THERE AN AUTOPSY? .....  
WHAT TEST CONFIRMED DIAGNOSIS? 100%  
(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

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

of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state WITH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

S-39581