

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

Do not use this space.

1. PLACE OF DEATH

County Dunklin
Township
City Malden (No. 41713)

Registration District No. 289
Primary Registration District No. 5407

File No. 40232
Registered No. 70
St. _____ Ward _____

2. FULL NAME

(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 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 Lelah Moore

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct-13-1863

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
66 2 16

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

9. BIRTHPLACE (CITY OR TOWN) Vermillion Co., Ind.
(STATE OR COUNTRY) Madison Co., Ill.

10. NAME OF FATHER A. A. Moore

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

12. MAIDEN NAME OF MOTHER E. E. Hite

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

14. INFORMANT Mrs. Lelah Moore
(Address) Malden Mo.

15. FILED 12/30, 1929 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 29 1929

17. I HEREBY CERTIFY, That I attended deceased from about Nov 14, 1929, to Dec. 29, 1929 that I last saw him alive on Dec 28, 1929, and that death occurred, on the date stated above, at 6 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

99%
Mitral Regurgitation
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 90%
(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) James Beale, M. D.
12/30, 1929 (Address) Malden 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 Malden Mo. DATE OF BURIAL 12-31 1929

20. UNDERTAKER W. L. Craig ADDRESS Malden

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 DEATH.
 County St. Louis Registration District No. 289 File No. _____
 Township _____ Primary Registration District No. 4173 Registered No. 70
 City Malden (No. _____) St. _____ Ward _____

2. FULL NAME Jarvis Achilles 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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.
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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) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 29 19 29

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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.

14. INFORMANT (Address) _____

15. FILED 12/30/29 St. Mitchell REGISTERAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____

20. UNDERTAKER _____ ADDRESS _____

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

SUPPLEMENTARY

5-40232