

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

Do not use this space.

43216

1. PLACE OF DEATH

County Texas
Township Wesley
City Houston (No.)

Registration District No. 813

Primary Registration District No. 4533

File No.

Registered No.

St. Ward

2. FULL NAME

Dale E. Moberly
(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)

Married

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

Sarah Jane Moberly

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

July 24 1900

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

29

4

15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

attorney

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Limmersville Mo

(STATE OR COUNTRY)

10. NAME OF FATHER

H. F. Moberly

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Ohio

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Anna Laidley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Mo

(STATE OR COUNTRY)

14.

INFORMANT (Address)

Mable Moberly

15.

FILED 2-9, 1925

Joe Moberly
REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-8-1929

17.

I HEREBY CERTIFY, That I attended deceased from 12-8-1929 to 12-8-1929, 1929, to 12-8-1929, 1929 that I last saw him alive on 12-8-1929, 1929, and that death occurred, on the date stated above, at 10:40 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gunshot wound in abdomen
Self inflicted

167

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19 DID AN OPERATION PRECEDE DEATH? DATE OF

20 WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) E. P. Blawie, 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

Bethel Cemetery

12-8 1929

20. UNDERTAKER

ADDRESS

Gaylord V. Elliott

Houston Mo

N. B.—Every item of information should be stated EXACTLY. PHYSICIANS. CAUSE OF DEATH in plain terms, so that it is statement of OCCUPATION is very

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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 Texas Registration District No. 863 File No.
 Township Primary Registration District No. 4522 Registered No.
 City Houston (No. St. Ward)

2. FULL NAME Dale E Moberly
 (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 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)

INFORMANT (Address)

15. FILED 19 1917 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-8-1917

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:
Gunshot wound in abdomen suicidal
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) (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

20. UNDERTAKER ADDRESS

PERMANENT RECORD should be accurately supplied. AGE should be carefully be properly classified. Exact statement of OCCUPATION is very important. SHALL NOT RECEIVE A FEE FOR CERTIFICATE. COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY 170

S-432.16