

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

Do not use this space.

14364

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. 791
Primary Registration District No. 1003
(No. 626 So. Broadway)

File No.....
Registered No. 3707
St..... Ward.....

2. FULL NAME

Rose Moore
(a) Residence, No. 626 So. Broadway 11 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 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 Frank Moore

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 18, 1877

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
52 7 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer At Home

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Sparta, Ill.

10. NAME OF FATHER Henry Moret

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

12. MAIDEN NAME OF MOTHER Sarah Brown

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

14. INFORMANT Jennie Stewart
(Address) 626 So. Broadway

15. FILED APR 21 1930 W. C. HULL REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 11, 1930

17. No physician in attendance
I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., and that I last saw him..... alive on....., 19....., and that death occurred, on the date stated above, at....., 7:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

94B
Coronary Sclerosis
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 91B
(duration) yrs. mos. ds.

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

8 DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed) Dr. J. H. ... M.D.

4/14, 1930 (Address) 626 So. Broadway
*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

Concordia April 14, 1930
20. UNDERTAKER ADDRESS

Bensick-Graham 1138 9th. 635

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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