

JUN 25 1930

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

Do not use this space.

16429

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.

1. PLACE OF DEATH

County Jackson
Township Crairie
City (No. _____) _____

Registration District No. 400
Primary Registration District No. 2502 B

File No. _____
Registered No. 776
St. _____ Ward _____

2. FULL NAME Lander J. Moore

(a) Residence No. Jackson County Home 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 Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-14-1852

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
78 4 16

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

10. NAME OF FATHER unknown

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 J. W. Hostetter
Jackson Co. Home

15. FILED W. H. James REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-30-1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to 5/30, 1930 that I last saw him alive on 5-27-30, 1930 and that death occurred, on the date stated above, at 10:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

chronic myocarditis
9 30
162 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) General inattention (duration) _____ yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

19. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) J. W. Greene M. D.
5/31, 1930 (Address) Independence 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 West Hill Cemetery DATE OF BURIAL 4 3 1930

20. UNDERTAKER Kelley ADDRESS KeMo

