

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

Do not use this space.

**1. PLACE OF DEATH**

County.....  
Township St. Louis Mo.  
City St. Louis Mo. (No. ....)

Registration District No. 791  
1003  
Primary Registration District No. ....  
Sanitarium

File No. ....  
Registered No. 31590  
9227  
St. .... Ward)

**2. FULL NAME**

(a) Residence No. 3816<sup>2</sup> boat (City) 13 Ward.  
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. + mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Female</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF  
Jacob Moore

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 10, 1902

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
	<u>28</u>	<u>8</u>	<u>12.</u>	

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.....

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

10. NAME OF FATHER.....  
Unknown

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

12. MAIDEN NAME OF MOTHER.....  
Unknown

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

14. \*INFORMANT.....  
(Address) Or Mullins M.D.  
5400 Arsenal

15. FILED.....  
REGISTRAR Ray C. Starkey

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-22-1930

17. I HEREBY CERTIFY, That I attended deceased from.....  
Aug 12, 1929, to 9-22, 1930  
that I last saw h. alive on..... 9-22, 1930, and that death occurred, on the date stated above, at..... 3:50 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS: 23A

Pulmonary Hemorrhage  
(duration)..... yrs..... mos..... ds.

CONTRIBUTORY (SECONDARY) Pulmonary tuberculosis  
(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? Clinical X-ray & laboratory  
(Signed) Or Mullins, M. D.

9-22-1930 (Address) 5400 Arsenal

\*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.....

Metairie La. 9-26-1930

20. UNDERTAKER..... ADDRESS.....  
A. F. Walton 2701 Stoddard

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.

