

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

Do not use this space.

34292

File No.
Registered No. **9643**
St. Ward)

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No. *2*
City..... *St. Louis* (No. *5433 Bates St*)

2. FULL NAME

(a) Residence. No. St. *2* 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) *Single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov 6th 1884*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
46 11 1

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) *St. Louis*
(STATE OR COUNTRY)

10. NAME OF FATHER *Lewis Moore*

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

12. MAIDEN NAME OF MOTHER *Margaret Donovan*

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

14. INFORMANT *Miss Nellie Moore*
(Address) *5433 Bates St*

15. FILED *May 25 1930*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct. 7, 1930*

17. I HEREBY CERTIFY, That I attended deceased from *August 14, 1930*, to *October 5, 1930* that I last saw him alive on *October 4, 1930*, and that death occurred, on the date stated above, at *2 P.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
121
730
(duration) *5* yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Chronic interstitial Nephritis*
(duration) *5* yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF -

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Physical Examination*
(Signed) *Walter C. Pischner* M. D.
Oct. 8, 1930 (Address) *508 N. Grand Blvd.*

*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 *Calvary* DATE OF BURIAL *10-10 1930*

20. UNDERTAKER *Arthur J. Donnelly* ADDRESS *2039 West St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Wm. W. G. A. Stuchiner

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