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

Do not use this space.

39232-A

File No. 39232-A
Registered No. 30

1. PLACE OF DEATH
County Howard
Township Franklin
City ..... (No. ....., ... St. ..... Ward)
Registration District No. 380
Primary Registration District No. 5530

2. FULL NAME Mrs S H Moore ~~Moore~~
(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: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF S H Moore

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April-1-1855

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
75	8	5	

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

9. BIRTHPLACE (CITY OR TOWN) Little Rock
(STATE OR COUNTRY) Ill

PARENTS
10. NAME OF FATHER Ovitt
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Va
12. MAIDEN NAME OF MOTHER Kay Abramahe
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT Mrs Jas McGavock
(Address) New Franklin Mo

15. FILED ~~12-7~~ 19~~30~~ 2-9-1931 B Fleet REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-6 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1930, to 12-6, 1930 that I last saw her alive on 12-6, 1930, and that death occurred, on the date stated above, at 12-6-30 3 P.m.

66 F THE CAUSE OF DEATH* WAS AS FOLLOWS:
97 Exopthalmic Goitre

Several years (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Arterio-Sclerosis
Unknown (duration) ..... yrs. ..... mos. ..... ds.

660

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
C DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? ✓
(Signed) B Fleet, M. D
12-7, 1930 (Address) New Franklin 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: Mt Pleasant
DATE OF BURIAL: 12-8 1930

20. UNDERTAKER: C S Duncan New Franklin Mo
ADDRESS

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.

39232-1