

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

Do not use this space.

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PLACE OF DEATH

County Dunklin
Township _____
City Malden (No. _____)

Registration District No. 289
Primary Registration District No. 4173

File No. _____
Registered No. 10
St. _____ Ward _____

2. FULL NAME Elizabeth Levina 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) Widow

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
77 7 15

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. at home
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. retired
10. Date deceased last worked at this occupation (month and year) 1930 11. Total time (years) spent in this life occupation life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Calaway Co., Mo.

FATHER 13. NAME Robert Allen Longley

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boston Mass.

MOTHER 15. MAIDEN NAME Clara W. Hinton

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bedford Ky.

17. INFORMANT (ADDRESS) Mrs. Mary H. Stokes

18. BURIAL, CREMATION, OR REMOVAL

PLACE Malden Mo DATE 1/18 1931

19. UNDERTAKER W. L. Craig

(ADDRESS) Malden Mo

20. FILED 1/18 1931 S. E. Mitchell
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 17 1931

22. I HEREBY CERTIFY That I attended deceased from Jan 14 1930, to Jan 17 1931
I last saw h. or alive on Jan 16 1931. Death is said to have occurred on the date stated above, at 2:35 a.m.

The principal cause of death and related causes of importance were as follows:

Myocarditis
1930
11 B
Other contributory causes of importance: Influenza
Date of onset Jan. 30

Name of operation None Date of _____
What test confirmed diagnosis? Symptoms of influenza Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____

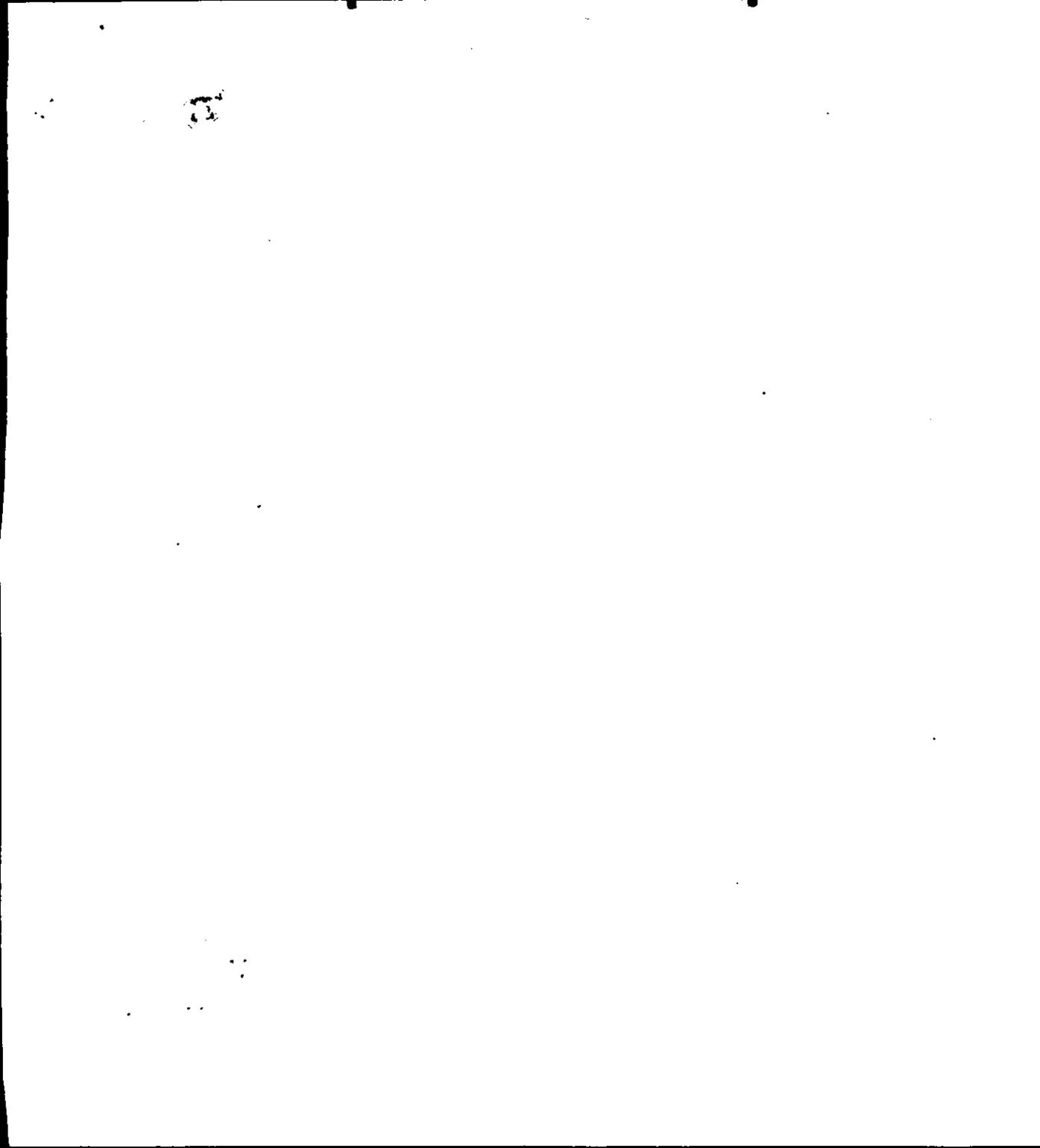
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No.
If so, specify _____
(Signed) Flora B. Bell, M. D.
(Address) Malden Mo

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.

FEB 18 1931



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Stuncklin Registration District No. 289 File No. _____
 Township _____ Primary Registration District No. 4173 Registered No. 10
 City Malden (No. _____) St. _____ (Ward)

2. FULL NAME Elizabeth Leona 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 2, 1953

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
77 7 15

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 17 19 31

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____ (that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____)

THE CAUSE OF DEATH* WAS AS FOLLOWS:
 _____ (duration) _____ yrs. _____ mos. _____ ds.

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

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) _____, M. D.
 _____, 19____ (Address)

*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 _____ 19____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

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

PARENTS

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT _____ (Address) _____

15. FILED 1/18 1931 St Mitchell REGISTRAR

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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