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

Do not use this space.

1320

1. PLACE OF DEATH

County Jackson — Registration District No. 3

Township Kaw — Primary Registration District No.

City K-C-Mo (No. 2560½ Holmes-Ave- St. Ward)

File No.

Registered No. 151

2. FULL NAME Norma Louise Moss -

(a) Residence. No. 2560½ Holmes St., 3 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Fe	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 24 - 1930

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	2	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Child
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Patrick Moss

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

12. MAIDEN NAME OF MOTHER Ollie Adams

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

14. INFORMANT Patrick Moss
(Address) 2560½ Holmes Ave. K.C. Mo

15. FILED Jan 12, 1931 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 12 1931

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1931 to Jan 12, 1931 that I last saw her alive on Jan 11, 1931, and that death occurred, on the date stated above, at 5 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Spina Bifida (Lumbar)

(duration) yrs. 2 mos. 18 ds.

CONTRIBUTORY (SECONDARY) Escape of Cerebro Spinal Fluid (Duration of Spina Bifida Sac)

(duration) yrs. mos. 7 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Entire Sac

DID AN OPERATION PRECEDE DEATH? DATE OF Jan 7-31

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J G Sheldon, M. D.

1-12, 1931 (Address) 6 of Corner Bldg

*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
Forest Hill	Jan 13 1931
20. UNDERTAKER	**ADDRESS**
Mrs. C. L. Forster	K.C. 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.

Commerce