

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

Do not use this space.

**3166**

**1. PLACE OF DEATH**

County.....  
Township.....  
City *St. Louis mo* (No. *4545*)

Registration District No. *791*  
Primary Registration District No. *1003*

File No.....  
Registered No. *380* (Ward)

**2. FULL NAME**

*Marguerite Moor*  
(a) Residence No. *4545 Newberry* St., *12* Ward.

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. (If nonresident, give city or town and State)

**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 *Henry Moor*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *9-6-1873*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
	<i>57</i>	<i>4</i>	<i>3</i>	

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work *Housewife*  
(b) General nature of industry, business, or establishment in which employed (or employer) *335*  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Va. 2*

10. NAME OF FATHER *Zachery Condit*

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

12. MAIDEN NAME OF MOTHER *Francis Hay*

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

14. INFORMANT *Henry Moor* (Address) *4545 Newberry Ter.*

15. FILED *11* REGISTRAR *1911*

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *1-9 1931*

17. *No. Physician in attendance*  
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 *6:30 A.M.*

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

*Chronic*  
*92A Endocarditis*  
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *92A* (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) *John A. Shirley M.D.*  
*1/10/31* (Address) *1001 Poplar Corner*

\*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 *Centralia Ill* DATE OF BURIAL *1-10 1930*

20. UNDERTAKER *McLaughlin* ADDRESS *1631 moore*

A. 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.

