

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

Do not use this space.

1. PLACE OF DEATH

County Jackson

Registration District No. 3

28354

File No.

Township New

Primary Registration District No. 14

Registered No. 3182

City Hannibal (No. St. Lukes Hospital)

St.

Ward

2. FULL NAME

(a) Residence No. 5521

(Usual place of abode)

St. 15

Ward.

(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

male

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)

aug. 15-31

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

1

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)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

St. Lukes Hospital

PARENTS

10. NAME OF FATHER

Reuben Emmet Moser

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

near Gullenburg Iowa

12. MAIDEN NAME OF MOTHER

alo Reberhard

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

near Gullenburg Iowa

14.

INFORMANT

(Address)

Reuben E. Moser

5521 Euclid

15.

FILED

8/16 1931 M. M. Kerowe

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Sunday Aug 16 1931

17.

I HEREBY CERTIFY, That I attended deceased from Aug 15, 1931 to Aug 16, 1931 that I last saw him alive on Aug 16, 1931, and that death occurred, on the date stated above, at 12:30 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fetal Atelectasis (Premature Infant)

153

161A

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (SECONDARY)

Fetal Atelectasis (Premature Infant)

(duration) yrs. mos. 1 ds.

18. WHERE WAS DISEASE CONTACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no. DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?

Post mortem

(Signed) Renneth G. Davis M. D.

9/16 1931 (Address) 330 Woodland Kansas City, 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

DATE OF BURIAL

Forest Hill

8-17-1931

20. UNDERTAKER

ADDRESS

Eylar Funeral Home

1800 Duwain

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

