

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 23 1932

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

Do not use this space.

302

## 1. PLACE OF DEATH

12 County Butler  
Township Exms.  
City \_\_\_\_\_ (No. \_\_\_\_\_) Ward \_\_\_\_\_

Registration District No. 480  
Primary Registration District No. 4-32

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

## 2. FULL NAME

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)  
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 M 4. COLOR OR RACE W 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) May 1 — 1928

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
3 8 10

## 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 \_\_\_\_\_

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

10. NAME OF FATHER Gas Moore

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

12. MAIDEN NAME OF MOTHER Bethel Stephens

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

14. INFORMANT Gas Moore  
(Address) Elkins Mo

15. FILED 4/12 1932 M. S. Caldwell  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 11 1932

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1932, to Jan 11, 1932, that I last saw him alive on Jan 11, 1932, and that death occurred, on the date stated above, at 2.30 P. M.

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

Infantile Paralysis

CONTRIBUTORY (SECONDARY) 16 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 18 ds.

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## 18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF ①

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
(Signed) L. C. Sheets, M. D.  
, 19 \_\_\_\_\_ (Address) Elkins 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 Trainer Cemetery DATE OF BURIAL 1/12 1932  
20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

