JAN 26 1934

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. 404 — File No. 40412
Township Washington — Primary Registration District No. 3338 — Registered No. 70
City ..... (No. 8006 College St. ..... Ward)

2. FULL NAME Johnnie Leon Moore
(a) Residence. No. Kansas City Mo Rt. 2 no. Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 4 mos. ..... da. How long in U.S., if of foreign birth? yrs. ..... mos. ..... da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 4-33

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
1	4	27	

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) .....
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER Harold Moore
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Mary Cochran
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ark.

14. INFORMANT J. D. Reed
(Address) 8002 College

15. FILED 12-31, 1933 B. F. Brammond
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 31 1933

17. I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1933, to Dec. 31, 1933 that I last saw him alive on Dec. 31, 1933, and that death occurred, on the date stated above, at 1020 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
1077
(duration) ..... yrs. ..... mos. 2 da.

CONTRIBUTORY (SECONDARY) 1077
(duration) ..... yrs. ..... mos. ..... da.

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) Geo. Jones, M. D
12/31/33, 19 (Address) 80 & Paseo

*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: Lounsbury Kansas
DATE OF BURIAL: Jan 1- 1934

20. UNDERTAKER: J. D. Reed
ADDRESS: 8002 College

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.

NAME PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD