

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

Do not use this space.

1. PLACE OF DEATH

County Boone

Registration District No. 72 ✓

File No. 7806

Township Centralia

Primary Registration District No. 4041

Registered No. 10

City Centralia (No. St. Ward)

2. FULL NAME

Norman Ray Moberg

(a) Residence, No. St. 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) Sept 29th 1930

7. AGE YEARS 3 MONTHS 5 DAYS 22 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Child

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. -

10. Date deceased last worked at this occupation (month and year) - 11. Total time (years) spent in this occupation -

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Centralia, Mo

13. NAME Calvin Moberg

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Centralia, Mo

15. MAIDEN NAME Freda Julia

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boone Co, Mo

17. INFORMANT (ADDRESS) Calvin Moberg, Centralia, Mo.

18. BURIAL, CREMATION, OR REMOVAL Centralia, Mo DATE - 19. -

19. UNDERTAKER (ADDRESS) M J McDonald

20. FILED 3/21 1934 H. H. Tiderson Registrar.

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 21st 1934

22. I HEREBY CERTIFY, That I attended deceased from Mar 15, 1934, to Mar 21, 1934.

I last saw him alive on March 21, 1934. Death is said to have occurred on the date stated above, at 11:30 A.m.

The principal cause of death and related causes of importance were as follows:

Menses Complicated with Bronchial Pneumonia Date of onset Mar 15 1934
Malnutrition
Congenital & Nutritional Disorders 4 years

Other contributory causes of importance -

Name of operation - Date of -
What test confirmed diagnosis? - Was there an autopsy? -

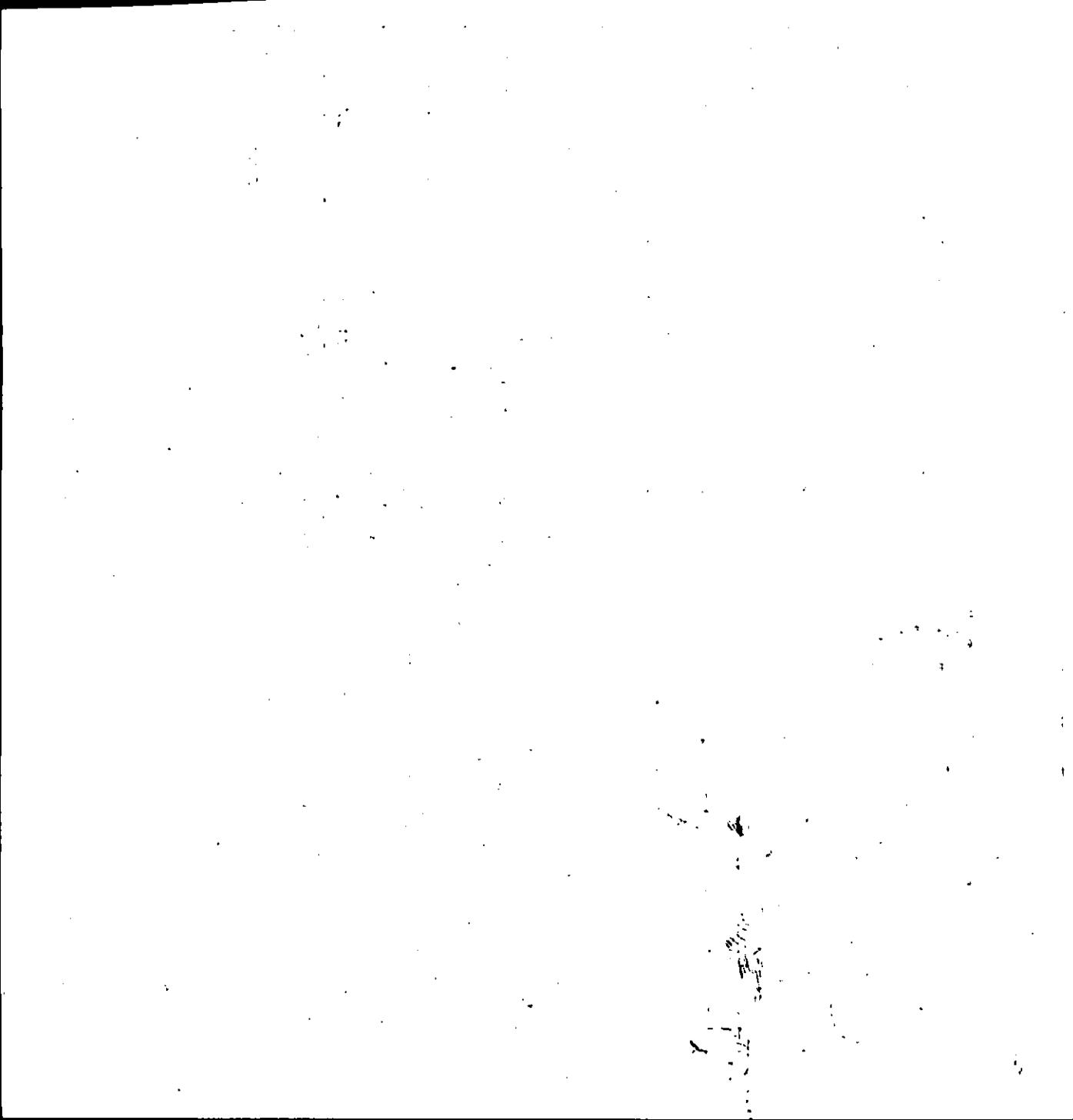
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? - Date of injury -, 19-

Where did injury occur? - (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury -
Nature of injury -

24. Was disease or injury in any way related to occupation of deceased? -

If so, specify -
(Signed) Frank W. Barden, M. D.
(Address) Centralia, Mo.



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Boone Registration District No. 72 File No. _____
 Township _____ Primary Registration District No. 4041 Registered No. 10
 City Centralia (No. _____, St. _____, Ward _____)

2. FULL NAME

(a) Residence, No. _____ St. _____ 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) _____

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

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

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER
 13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
 15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE 3/22-1934

19. UNDERTAKER (ADDRESS) _____

20. FILED _____ 19 (J. T.) Nelson Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 21, 1934

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h_____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____.

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) _____, M. D.

(Address) _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-7806