

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.

APR 25 1934

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

Do not use this space.

10406

1. PLACE OF DEATH

County..... Registration District No. **701**
Township..... Primary Registration District No. **1003**
City..... *St. Louis* (Name of City).....

File No.....
Registered No. **2202**
St..... Ward.....

2. FULL NAME

Fannie B. Moore
(a) Residence, No. *4481 Forest Park St.*, *19* 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 <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>John D.</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Jan 25, 1884</i>		
7. AGE YEARS <i>50</i>	MONTHS <i>1</i>	DAYS <i>7</i>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>at Home</i>		
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) <i>Peoria, Ill.</i>
MOTHER FATHER
13. NAME <i>Gabriel Meiers</i>
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Ill.</i>
15. MAIDEN NAME <i>Emma Eberhardt</i>
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Ill.</i>
17. INFORMANT (ADDRESS) <i>John D. Moore 4481 Forest Park</i>
18. BURIAL, CREMATION, OR REMOVAL PLACE DATE <i>Valhalla Cem. 3-5-34</i>
19. UNDERTAKER (ADDRESS) <i>W. Hoffmeister & Co. 1078 1/2 S. Broadway</i>
20. FILED <i>J. Bredeck</i> Registrar.

No 2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *March 2*, 19*34*

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

I last saw him alive on 19..... Death is said to have occurred on the date stated above, at *4:30 p.m.*

The principal cause of death and related causes of importance were as follows:
Chronic Parenchymatous Nephritis
Partial degeneration of cardiac muscle

Other contributory causes of importance:
13! 13!

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? *yes*

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
3/3/34

(Signature) *Parasol P. Chung*
(Address) *Dep. Gen. Sec.*

