

MAY 25 1934

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

Do not use this space.

15453

APR 25 1934

1. PLACE OF DEATH *Stoddard*
County *Stoddard* Registration District No. *840*
Township *Stoddard* Primary Registration District No. *6102*
City (No.) St. Ward)

2. FULL NAME *Frank Moyan*
(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

MEDICAL CERTIFICATE OF DEATH

3. SEX <i>Male</i>	4. COLOR OR RACE <i>W</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF <i>X</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Don't know</i>		
7. AGE	YEARS	MONTHS
<i>About 21</i>		
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Farmer</i>		11. Total time (years) spent in this occupation
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)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>MO</i>		
13. NAME <i>Frank Moyan</i>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Don't know</i>		
15. MAIDEN NAME <i>Don't know</i>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Don't know</i>		
17. INFORMANT (ADDRESS) <i>John Ellinger</i> <i>Paris, Mo</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Home cemetery</i> DATE <i>4/2 34</i>		
19. UNDERTAKER (ADDRESS) <i>Don't know</i>		
20. FILED <i>4/2 34</i> <i>E. L. Hope</i> Registrar		

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *April 1st 1934*

22. I HEREBY CERTIFY, That I attended deceased from *3-20*, 1934, to *April 31, 1934*
I last saw him alive on *3-28*, 1934 Death is said to have occurred on the date stated above, at *5 p.m.*
The principal cause of death and related causes of importance were as follows:
Pneumonia Date of onset

Other contributory causes of importance:
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Name of operation Date of
What test confirmed diagnosis? *X* Was there an autopsy?

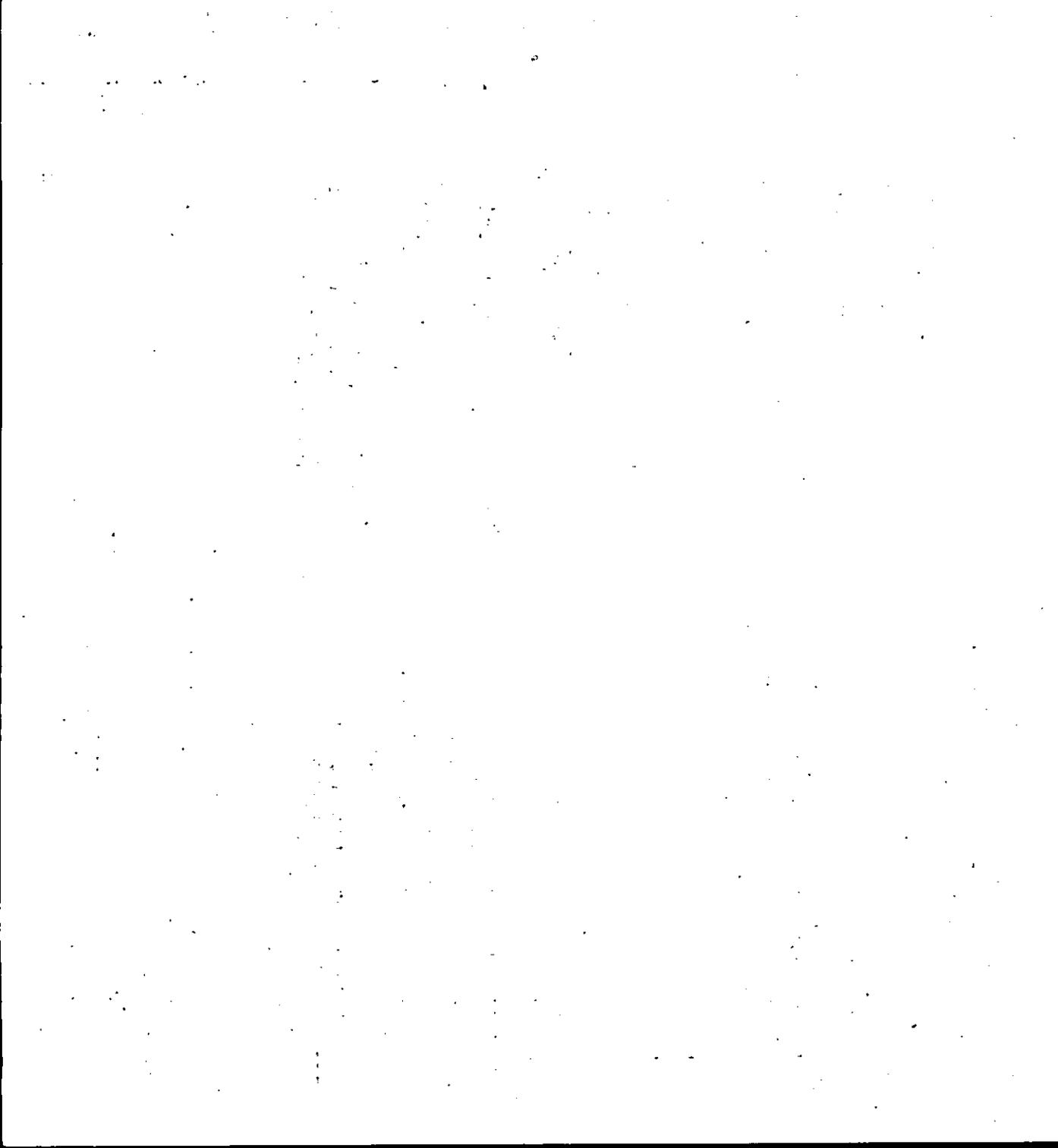
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19

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 *T*

24. Was disease or injury in any way related to occupation of deceased? *NO*
If so, specify *N. E. G. Atherton*, M. D.
(Signed) *Purvis* (Address) *MO*

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.



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Stoddard Registration District No. 840
 Township Duck Creek Primary Registration District No. 6102
 City (No. _____ St. _____ Ward _____)

File No. _____
 Registered No. 22

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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 1, 1934

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

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

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Don't know
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
About 21 1 1

Date of onset

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 _____

Spontaneous
terrible pneumonia
liber pneumoniae
 Other contributory causes of importance: _____

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

13. NAME _____

Name of operation _____ Date of _____

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

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

15. MAIDEN NAME _____

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

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

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

17. INFORMANT (ADDRESS) _____

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

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____, 19____

Manner of injury _____

19. UNDERTAKER (ADDRESS) _____

Nature of injury _____

20. FILED 4/2 1934 E. L. Hope Registrar.

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

If so, specify _____

(Signed) _____, M. D.

(Address) _____

SUPPLEMENTARY

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CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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