

REC'D MAR 15 1938

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

6449  
Do not use this space.

1. PLACE OF DEATH
- (a) County Christian Registration District No. 184
- (b) Township M. Hallaway Primary Registration District No. 5256 Registered No. 111
- (c) City ..... (d) Street No. .... St.
- (If death occurred in Hospital or Institution, write its name instead of street and number)
- (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Genevieve Irene Moore 600
- (a) Residence, No. .... St.  (If nonresident, give city or town and State)
- (Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>single</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>single</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb. 13-1933</u>				
7. AGE	YEARS <u>4</u>	MONTHS <u>11</u>	DAYS <u>16</u>	If LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.			
	9. Industry or business in which work was done, as 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) <u>Mo.</u>				
FATHER	13. NAME <u>Lewis Moore</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>			
MOTHER	15. MAIDEN NAME <u>Ida Bell Holstein</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>			
17. INFORMANT <u>Lewis Moore</u> (ADDRESS) <u>Hoplandville Mo.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Jones Cem</u> DATE <u>Jan. 30-38</u>				
19. FUNERAL DIRECTOR <u>J.W. Maples</u> (ADDRESS) <u>Chester Mo.</u>				
20. FILED <u>Feb. 5 1938</u> <u>Loretta Leonard</u> Local Registrar. <u>170</u>				

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 29-1938

22. HEREBY CERTIFY That I attended deceased from Jan. 28 1938 to Jan. 29 1938

I last saw her alive on Jan. 29 1938. Death is said to have occurred on the date stated above, at 4 P. m.

The principal cause of death and related causes of importance were as follows:  
Brancho-Pneumonia  
about 11/23/38

Other contributory causes of importance:  
Acute Nephritis - Present  
just last visit

Name of operation ..... Date of .....  
What test confirmed diagnosis? Physic Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? X Date of injury X, 19.....  
Where did injury occur? X (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury X  
Nature of injury X

24. Was disease or injury in any way related to occupation of deceased? .....  
If so, specify .....  
(Signed) R.B. Mason, M. D.  
Missa Mo. (Address)

107a

STATEMENT BY LICENSED EMBALMER

I, J. H. Maples, Licensed Embalmer No. 2985

hereby certify that the body recorded on the reverse side of this certificate was <sup>not</sup> embalmed by

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed J. H. Maples

Licensed Embalmer No. 2985

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

Vertical text on the right edge of the page, including "Department of Health" and "Bureau of Health Services".

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

6449  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Christian Registration District No. 184  
 (b) Township Ballouay Primary Registration District No. 325-6 Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Geneva Irene Moore  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 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) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
4 11 16

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 9. Industry or business in which work was done, as 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 \_\_\_\_\_ 19

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED Feb 5 1938 Luella Leonard Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 29 1938

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:  
Broncho pneumonia Date of onset \_\_\_\_\_  
11/2  
 Other contributory causes of importance: acute nephritis present on my first visit  
Influenza  
 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 W. B. Wasson M. D.  
 (Signed) \_\_\_\_\_ (Address) Nipa mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
 N. B.—Every item of information 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.

