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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

REC'D AUG 27 1938

26794
Do not use this space.

1. PLACE OF DEATH

(a) County Webster — Registration District No. 896

(b) Township Ozark — Primary Registration District No. 6198 — Registered No. 23

(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 Grundy Walter Moore 60-D

(a) Residence, No. ..... St. [ ]
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Idonia C. Moore

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): June 14, 1868

7. AGE — YEARS: 80 — MONTHS: 1 — DAYS: 3 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Mason
9. Industry or business in which work was done, as saw mill, bank, etc.: Buildings
10. Date deceased last worked at this occupation (month and year): 1928
11. Total time (years) spent in this occupation: life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Polk County 0

FATHER

13. NAME: William H. Moore 9
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown 9

MOTHER

15. MAIDEN NAME: Serena Mc Swain
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

17. INFORMANT (ADDRESS): Mrs. Idonia C. Moore, Marshfield, Missouri.

18. BURIAL, ~~CREMATION, OR REMOVAL~~
PLACE: Marshfield DATE: July 19, 1938

19. FUNERAL DIRECTOR (NAME): Rex Rainey
(ADDRESS): Marshfield, Missouri.

20. FILED July 20, 1938 Elizabeth Haffner
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): July 17, 1938

22. I HEREBY CERTIFY, That I attended deceased from July 13, 1938, to July 17, 1938
I last saw him alive on July 13, 1938. Death is said to have occurred on the date stated above, at 9 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Hemiplegia left side	

Other contributory causes of importance:
Uremic poisoning with enlarged prostate.

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) W. A. Bruce M. D.
(Address) Marshfield Mo.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, X Rex Rainey, or by X

Registered Apprentice No. X, working under my personal supervision.

Signed Rex Rainey

Licensed Embalmer No. 3312

P. O. Address Marshfield, Missou

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.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

26794
Do not use this space.

1. PLACE OF DEATH
(a) County Webster — Registration District No. 896
(b) Township Ozark — Primary Registration District No. 6198 — Registered No.
(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 Grundy Walter Moore
(a) Residence, No. — St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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.
	80	1	3	

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)

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 — 19 — *Local Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 17, 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:

Hemiplegia left side — Date of onset
Caused by cerebral hemorrhage
8 Jul

Other contributory causes of importance:
Uremic Poisoning with Enlarged Prostate

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) J. R. Bruce, M. D.
(Address) Marshfield Mo

SUPPLEMENTARY

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.

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