

WRITE PLAINLY, WITH UNFADING INK...THIS IS A PERMANENT RECORD

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.

66-10-31  
MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

42359  
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85  
 (b) Township St Joseph Mo Primary Registration District No. 100  
 or St Joseph Mo  
 (c) City St Joseph Mo (d) Street No. State Hosp # 2 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 3014-E-20 Kansas City Mo 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 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 Olive Moore

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 3 1857

7. AGE YEARS 81 MONTHS 6 DAYS 8 If LESS than 1 day, .....hra. or .....min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired  
 9. Industry or business in which work was done, as saw mill, bank, etc. Farmed  
 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) Indiana

FATHER 13. NAME Wm F Moore

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

MOTHER 15. MAIDEN NAME Jane Swain

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

17. INFORMANT (ADDRESS) Wm P. Moore 3014-E-20 Kansas City Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE Dec 13 1938 R.C. No. .....

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm C Lyster 714 Brooklyn R.C. No. ....

20. FILED Dec 11 1938 A. J. Hestlebach Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 11 1938

22. I HEREBY CERTIFY, That I attended deceased from Dec 1 1938, to Dec 11 1938

I last saw him alive on Dec 11 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:

Broncho Pneumonia

Date of onset

Other contributory causes of importance: 107 N

Name of operation no Date of .....  
 What test confirmed diagnosis? Chin Was there an autopsy? no

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 none  
 Nature of injury none

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify no  
 (Signed) W Bright, M. D.  
 (Address) State Hosp # 2

**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, or by

C. H. Wise # 2570 Mo, Registered Apprentice No. Geo Lile  
working under my personal supervision.

Signed

Mrs C. L. Jaster

Licensed Embalmer No.

25706 H.W.

P. O. Address

918 Brooklyn K.C.

**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.**