JAN 25 1939

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

Do not use this space. 42949

1. PLACE OF DEATH
(a) County Douglas
(b) Township Ward 1
(c) City Mtn Grove Mo (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.

Registration District No. 908
Primary Registration District No. 6223
Registered No. 62

2. PRINT FULL NAME 65 Mary Elizabeth Balfour 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: Female
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: Charles Moore
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Nov. 18-1856
7. AGE: Years 82 | Months 0 | Days 17 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: House Wife
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): Adams Co Ill.

FATHER
13. NAME: Nixon Balfour
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Randolph Co N.C.

MOTHER
15. MAIDEN NAME: Keziah Lisman Robbins
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Randolph Co N.C.

17. INFORMANT (ADDRESS): Mr. Charles Moore

18. BURIAL, CREMATION, OR REMOVAL
PLACE Arcadia Ill. DATE Dec 10 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Bottom Funeral Home 831

20. FILED 12-10 1938 Bernice Montgomery Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 6 1938

22. I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1938, to Dec. 6, 1938
I last saw h.e.r. alive on Dec. 6, 1938. Death is said to have occurred on the date stated above, at 3 P. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Bronchial Pneumonia	

Other contributory causes of importance:
Fracture of neck of left femur.

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) R. W. Cleaveny, M. D.
(Address) 4th. & Front Sts.

Licensed Embalmer's Statement on Reverse Side)

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.

I X14028

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, George Stapp, or by .....,

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

Signed George Stapp

Licensed Embalmer No. 3161

P. O. Address Mtn. Grove Mo.

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
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CERTIFICATE OF DEATH

42949

Do not use this space.

1. PLACE OF DEATH
(a) County: Wright — Registration District No.
(b) Township — Primary Registration District No. — 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: Mary E. B. 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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): W

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

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

7. AGE: Years 82 — Months — — Days 17 — 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)

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) 12 - 6, 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:

	Date of onset
Acute Bronchial Pneumonia	

Other contributory causes of importance:

Fracture of neck of left femur	

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? Accident — Date of injury 11-28, 1938
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
due to a fall in home
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) R. M. Denny, M. D.
(Address) Mtn Grove 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 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.