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

Do not use this space.

5809

1. PLACE OF DEATH

County Jackson — Registration District No. — File No.

Township Kaw — Primary Registration District No. — Registered No. 973

City K.C. Mo (No. Research Hosp St. Ward)

2. FULL NAME Moore, Mrs Nora

(a) Residence. No. Orrick Mo St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11-24-1889

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	41	2	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife 235
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Polo
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Joseph Green

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Delilah Albright

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo

14. INFORMANT W. J. Moore
(Address) Orrick Mo

15. FILED 7/24 1931 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 20 1931

17. I HEREBY CERTIFY, That I attended deceased from Feb 17, 1931, to Feb 20, 1931 that I last saw her alive on Feb 20, 1931, and that death occurred, on the date stated above, at 7:50 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hyperemesis Gravidarium
Acute Diabetes
147
59 (duration) yrs. 4 mos. ds.

CONTRIBUTORY (SECONDARY) Diabetic Coma
(duration) yrs. mos. 7 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Home
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy - Clinical
(Signed) John H. Ogilvie, M. D.
7/20/31 (Address) 1002 Argyle

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Union Cem. Ray Co. Mo	2/24 1931
20. UNDERTAKER	**ADDRESS**
Gibson Und. Co	Orrick, 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.

WHITE PERIODICAL WITH UNFADING INK—THIS IS A PERMANENT RECORD