NOV 24 1931

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

Do not use this space.

34066

1. PLACE OF DEATH

County Dunklin — Registration District No. 284 — File No. ✓

Township Holcomb — Primary Registration District No. 5404 — Registered No.

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME (Premature Infant) Moore

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

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)
Girl	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-2-1931

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, 14 hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Frances Moore

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

12. MAIDEN NAME OF MOTHER Vallie E. Hicks

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

14. INFORMANT Frances Moore
(Address) Holcomb Mo

15. FILED ....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-3 1931

17. I HEREBY CERTIFY, That I attended deceased from 10-2, 1931, to 10-3, 1931 that I last saw her alive on 10-2, 1931, and that death occurred, on the date stated above, at 3 P.M. a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Unknown
(Premature birth)

159 (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (SECONDARY) 159 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED ✓

IF NOT AT PLACE OF DEATH ✓

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) S. T. Smith, M. D.

10/3, 1931 (Address) Holcomb

*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
Family Cem	10-3 1931
20. UNDERTAKER	**ADDRESS**
Family	Holcomb

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY L

1. PLACE OF DEATH

County: Franklin — Registration District No.: 286 — File No.:

Township: Falcomb — Primary Registration District No.: 5404 — Registered No.:

City: ..... (No. ....., ... St. ..... Ward)

2. FULL NAME: Infant Moore

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

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*)
F	W	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.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, 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. UNDERTAKER (ADDRESS)

20. FILED Oct. 3, 1931 J. A. Anderson Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 3, 1931

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

Other contributory causes of importance:

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) ....., M. D.

(Address) .....

SUPPLEMENTARY

3-34066