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.

REC'D MAR 9 1939

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

5394
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson — Registration District No. 399

(b) Township Kan — Primary Registration District No. 1002 — Registered No. 593

(c) City Kansas City — (d) Street No. K C Gen Hosp 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 Viola Mae Moon

(a) Residence, No. 4809 E. 17th 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): Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 30 1931

7. AGE — YEARS: 8 — MONTHS — DAYS: 10 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. School girl
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) Mo

FATHER
13. NAME Gifford Moon
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER
15. MAIDEN NAME Bonnie Myers
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Record Clerk K C Gen Hosp K C Mo

18. BURIAL, CREMATION, OR REMOVAL Greenlawn Cem DATE 2-11-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Peter B. Lapetrace 536 Campbell

20. FILED 2/12, 1939 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-10, 1939

22. I HEREBY CERTIFY, That I attended deceased from 2-9, 1939, to 2-10, 1939.
I last saw her alive on 2-10, 1939. Death is said to have occurred on the date stated above, at 8:25 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Tracheo pharyngeal	
Diphtheria	10

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? Yes

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) P. H. De Maria, M. D.
(Address) Supt K C Gen Hosp K C 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, ...

....., or by .....

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

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