

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No. **29067**

Towaship.....

Primary Registration District No. **1003**

Registered No. **8574**

City **St. Louis Children's Hosp.**

500 S. Kingshighway - St. Louis, Mo.

P.C. Ward

2. FULL NAME

(a) Residence No. **7 Beverly Pl. St., P.C. Ward 5**

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** | 4. COLOR OR RACE **White** | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **8-6-28**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
			17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **St. Louis Mo.**
(STATE OR COUNTRY)

10. NAME OF FATHER **Stanley Moon**

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

12. MAIDEN NAME OF MOTHER **Julia Lee**

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

14. INFORMANT **Impelrik**
(Address) **500 S. Kingshighway**

15. FILED **3 24 1928**
May C. Starbuck
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **8-23-1928**

17. I HEREBY CERTIFY That I attended deceased from **8/21, 1928**, to **8-23-1928**, that I last saw him alive on **8/23, 1928**, and that death occurred, on the date stated above, at **5/8m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Congenital debility
119B
640 (duration) yrs. mos. **16. da.**
15x CONTRIBUTORY **Acute diarrhoea - 10 da**
(SECONDARY)
Diarrhoea (duration) **0** yrs. **0** mos. **3. da.**

18. WHERE WAS DISEASE CONTRACTED **Home**
IF NOT AT PLACE OF DEATH:

19. DID AN OPERATION PRECEDE DEATH? **No.** DATE OF

20. WAS THERE AN AUTOPSY?

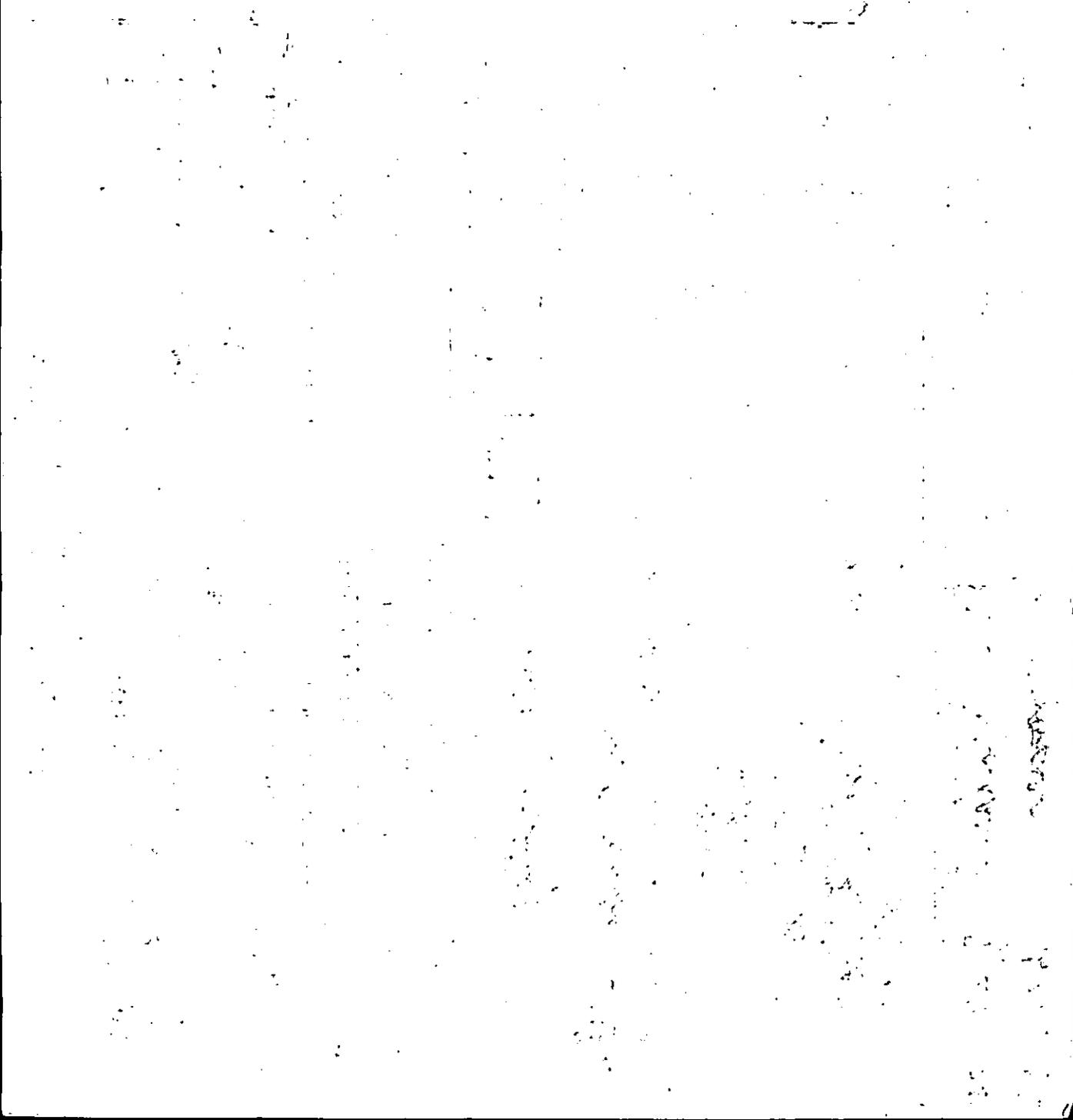
WHAT TEST CONFIRMED DIAGNOSIS? **Examination**
(Signed) **A. C. Edwards**, M. D.

8-23, 1928 (Address) **500 S. Kingshighway**

*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 **Bellfontaine** DATE OF BURIAL **8-24-1928**

20. UNDERTAKER **W. Rogers** ADDRESS **3621 Olive**



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County St. Louis Registration District No. 491 File No. _____
 Township _____ Primary Registration District No. 1003 Registered No. 85-94
 City _____ (No. _____) St. _____ (Ward)

2. FULL NAME Joseph Wm. Moon

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) 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.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

15.

FILED 10 May 6 Stark copy
 REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-23-28

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONGENITAL DEBILITY
 (duration) yrs. mos. ds.
 CONTRIBUTORY acute diarrhoea - 10 ds
 (SECONDARY)
acidosis non diabetic, information
 (duration) yrs. mos. ds.
given over phone by Dr. A. S. Edwards

18. WHERE WAS DISEASE CONTRACTED air of W. B. 10-9-28
 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) 113B M. D.

, 19 (Address) _____

*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

19

20. UNDERTAKER ADDRESS

S-29067