

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.

DEC 13 1937

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

39124
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. 791
(b) Township Primary Registration District No. 12083
(c) City St. Louis, Missouri (d) Street No. St. Louis Childrens Hospital Registered No. 10111
(If death occurred in Hospital or Institution, write its name instead of street and number) St.
(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 Charles Henry Moran

(a) Residence, No. (Usual place of abode, if no street address, write county or city) St. NR Montgomery City, Missouri
(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 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) February 25th, 1937

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
8 2

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Nil
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) Montgomery City, Missouri

FATHER
13. NAME William J. Moran

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Montgomery City, Missouri

MOTHER
15. MAIDEN NAME Thelma Jones

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Chesterfield, Illinois

17. INFORMANT (ADDRESS) William J. Moran
Montgomery City, Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Montgomery City, Mo. DATE October 28th 37

19. FUNERAL DIRECTOR (ADDRESS) Albert H. Hoppe Inc.,
429 N. Euclid Avenue

20. FILED NOV 1 1937 J. Predeck
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) October 27th 19 37

22. I HEREBY CERTIFY, That I attended deceased from Birth 2-25-37, 1937, to 10-27, 1937
I last saw him alive on Oct 27, 1937. Death is said to have occurred on the date stated above, at 2:00 P.M.

The principal cause of death and related causes of importance were as follows:

Serous Meningitis
Whooping Cough & Pneumonia
Date of onset 10-22-37

Other contributory causes of importance:
Whooping Cough
Bilateral Bacteraemia
Dehydration
Pneumonia
Date 9-11-37
10-8-37
10-24-37

Name of operation None Date of _____
What test confirmed diagnosis Signs & symptoms Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No Date of injury _____, 19____
Where did injury occur? None (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) E. J. T. Anderson, M. D.
(Address) Montgomery City, Mo.

1110E

1110E

STATEMENT BY LICENSED EMBALMER

I, Albert H. Hoppe, Licensed Embalmer No. 1861

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed

Albert H. Hoppe

Licensed Embalmer No. 1861

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.)