

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution City Hospital, #1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 Days
 (Specify whether
 In this community 20
 years, months or days)

3. (a) PRINT FULL NAME Charles Moore8. (b) If veteran, name war NO 8. (c) Social Security No. NO4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 1 18 1885
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
55 0 12 hr. _____ min.9. Birthplace POLA ND 7
(City, town, or county) (State or foreign country)10. Usual occupation unemployed 711. Industry or business _____ 912. Name Unknown 913. Birthplace 11 _____
(City, town, or county) (State or foreign country)14. Maiden name 11 _____15. Birthplace 11 _____
(City, town, or county) (State or foreign country)16. (a) Informant Dorais Cartrell(b) Address 1943 Franklin ave17. (a) Burial (b) Date thereof 2-2-40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Mount Hope18. (a) Signature of funeral director Central Mch. Co.(b) Address 1941 Cass ave19. (a) FEB 1 1940 (b) _____
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(b) State Mo (b) County _____
 (c) City or town St Louis 21
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1943 Franklin ave
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. 30 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 30,
year 1940 hour 12:00 minute A. M.21. I hereby certify that I attended the deceased from January
21, 1940 to January 30, 1940
that I last saw h. im alive on January 30, 1940
and that death occurred on the date and hour stated above.Immediate cause of death Cardiac HypertrophyDue to Ischemic Heart Disease

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: MI

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____23. Signature E. J. [Signature] (M. D. or other)
Address 1515 Lafayette Date signed 1/30/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1016

1016

5 3 8
1-5-1
9 3 6 1

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 *Albert G. Hoffa*

Licensed Embalmer No. *2971*

P. O. Address.....

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.)

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