

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36716**
Registrar's No. **8989**

Registration District No. **791** Primary Registration District No. **1003**

FILED DEC 11 1940

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Phillips Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 days** (Specify whether
In this community **23 years** (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **Rosie Moore**
8. (b) If veteran, name war _____ 8. (c) Social Security No. **Unk**

4. Sex **F** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **M**
6. (b) Name of husband or wife **Henry Moore** 6. (c) Age of husband or wife if alive **Unk** years
7. Birth date of deceased **Unknown** (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
Abt 39 hr. min.

9. Birthplace **Tenn** (City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business **Home**

12. Name **George Hester**

13. Birthplace **Unk** (City, town, or county) (State or foreign country)

14. Maiden name **Luoy**

15. Birthplace **Unk** (City, town, or county) (State or foreign country)

16. (a) Informant **Florence A. Spalte**
(b) Address **2601 N Whittier**

17. (a) (Burial, cremation, or removal) **St Louis** (b) Date thereof **12/7/40** (Month) (Day) (Year)

(c) Place: burial or cremation **St Louis**

18. (a) Signature of funeral director **W. Risher**

(b) Address **NOV 1 1940 3520 Kilday**

19. (a) (Date received local registrar) (b) **J. H. [Signature]**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St Louis** **25**
(If outside city or town limits, write "RURAL")
(d) Street No. **1115 N 17th**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **28**
year **1940** hour **1:45** minute **A. M.**

21. I hereby certify that I attended the deceased from **Sept 22**, 1940, to **Sept 28**, 1940;
that I last saw her alive on **Sept 28**, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death **Gangrenous Stomatitis**
Cellulitis of Face & Neck
Hypertensive Heart Disease
Uremia
Due to **98a**

Duration
14 das
Indef
8 das

Other conditions (include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

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. A. McDowsee** (M. D. or other) _____
Address **2601 N Whittier** Date signed _____

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MOTHER FATHER

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 comply the above constitutes grounds for revocation of license.)

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