

NOV 13 1943

Registration District No. 317

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St Louis
 (b) City or town Koch
 (c) Name of hospital or institution: Robert Koch Hosp
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 mo, 16 days
 In this community 62 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME AL MOORE

3. (b) If veteran, name war No 3. (c) Social Security No. NO

4. Sex M 5. Color or race C 6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased March 7 1881
 (Month) (Day) (Year)

8. AGE: Years 62 Months 7 Days 26 If less than one day hr. min.

9. Birthplace St Louis Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation Teamster

11. Industry or business

MOTHER FATHER { 12. Name William H Moore
 { 13. Birthplace Virginia
 { 14. Maiden name Betty Ray
 { 15. Birthplace 9

16. (a) Informant Hospital Record

(b) Address Robert Koch Hosp

17. (a) Burial (b) Date thereof 11-9-43
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem.

18. (a) Signature of funeral director Bernice Love

(b) Address 3093 Washington

19. (a) NOV 10 1943 (b) E. D. Mc Loren, M.D.
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17
 (c) City or town St Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 312 CONVENT
 (If rural, give location)
 (e) Citizen of foreign country? (Yes or No) 1
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 2
 year 1943 hour 10 minute 15-A.M.

21. I hereby certify that I attended the deceased from Aug 17 1943 to Nov 2 1943
 that I last saw him alive on Nov 2 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 6 mo?

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 13/1 PHYSICIAN

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) (a) Means of injury

23. Signature Frank Cohen (M. D. or other)
 Address Robert Koch Hosp Date signed 11/2/43

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

26
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NOV 29 1944

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 *Arthur L. Hilliard*

Licensed Embalmer No. *4821*

P. O. Address *4219th E Garfield*

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, fact should be so stated above.