No. 300
10.48

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

FILED MAR 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10429

State File No.

BIRTH NO. #94051 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2193

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis, Mo.
c. LENGTH OF STAY (in this place) 0
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Louis City Hospital #1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
d. STREET ADDRESS (If rural, give location) 3715 Olive

3. NAME OF DECEASED (Type or Print)
a. (First) LIONEL b. (Middle) c. (Last) MOISE

4. DATE OF DEATH (Month) (Day) (Year) March 8th, 1949

5. SEX Male **6. COLOR OR RACE** White **7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify) Married **8. DATE OF BIRTH** 12/31/1889 **9. AGE** (In years last birthday) 59 IF UNDER 1 YEAR: Months 2 Days 7 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Clerk
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Dallas, Tex.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Ruth C.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W. W. #1
16. SOCIAL SECURITY NO. 460-10-4781
17. INFORMANT'S SIGNATURE OR NAME Ruth Moise **ADDRESS** 3715 Olive

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) T.B. Far advanced
DUE TO (c) 13

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. No 2X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/19/49, 19__, *to* 3/8/49, 19__, *that I last saw the deceased alive on* 3/8/49, 19__, *and that death occurred at* 8:30 AM *from the causes and on the date stated above.*

23a. SIGNATURE Robert A. Vitt M.D. (Degree or title)
23b. ADDRESS 1515 Lafayette Ave.,
23c. DATE SIGNED 3/8/49

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
24b. DATE 3/10/49
24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery
24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.

DATE REC'D BY LOCAL REG. MAR 9 1949
REGISTRAR'S SIGNATURE J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Provart Und. Co., 3710 N. Hand

(Licensed Embalmer's Statement on Reverse Side)

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 ....., Student Embalmer No. ....., working under my personal supervision.

Signed Albert Mayfield

Signed .....
Student Embalmer

Licensed Embalmer No. 3077

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, fact should be so stated above.