

FILED SEP 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28359
Registrar's No. 7353

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH
a. COUNTY _____
2. USUAL RESIDENCE (Where deceased lived. *If institution: residence before admission).
a. STATE Mo b. COUNTY Mo

b. CITY (If outside corporate limits, write RURAL and give township) St Louis c. LENGTH OF STAY (In this place) _____
c. CITY (If outside corporate limits, write RURAL and give township) St Louis 17

d. FULL NAME OF HOSPITAL OR INSTITUTION Homearr G. Phillips Hospital
d. STREET ADDRESS (If rural, give location) 21 2935 Olive

3. NAME OF DECEASED a. (First) Arthur b. (Middle) _____ c. (Last) Moore
4. DATE OF DEATH (Month) (Day) (Year) August 18 1949

5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH July 1, 1882
9. AGE (In years last birthday) 67 IF UNDER 1 YEAR Months 1 Days 18 IF UNDER 4 WKS. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) La Porter 10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (State or foreign country) Georgia 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 Louise Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) _____
16. SOCIAL SECURITY NO. _____ 17. INFORMANT'S SIGNATURE OR NAME Louise Moore ADDRESS 2935 Olive

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES DUE TO (b) Hypertensive Heart Disease
DUE TO (c) Undetermined
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

INTERVAL BETWEEN ONSET AND DEATH Undet.

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

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

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 331X

22. I hereby certify that I attended the deceased from 8-11, 1949, to 8-18, 1949, that I last saw the deceased alive on 8-18, 1949, and that death occurred at 6:45P m., from the causes and on the date stated above.

23. SIGNATURE (Degree or title) James J. Hedrick M. D. 23b. ADDRESS 2601 N Whittier St 23c. DATE SIGNED 8-20-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE Aug. 25, 1949 24c. NAME OF CEMETERY OR CREMATORY: Washington Park 24d. LOCATION (City, town, or county) (State) St. Louis MO.

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE AUG 24 1949 J.B. Kasator 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Alfred English U. 60. 2931 Loc 95

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

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.

Student
Student Embalmer

Signed Burleson English

Licensed Embalmer No. 4208

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.