

FILED APR 25 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14586

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3050**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY OR TOWN St Louis Mo	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St Louis Mo. 2229	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 22 2600 Market Street	

3. NAME OF DECEASED (Type or Print) William Moore			4. DATE OF DEATH (Month) (Day) (Year) March 27 1952		
a. (First)	b. (Middle)	c. (Last)			

5. SEX Male	6. COLOR OR RACE Cold	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH not known abt 58	9. AGE (in years last birthday) abt 58	10. MONTHS 	11. DAYS 	12. HOURS 	13. MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Okolona, Mississippi	11. BIRTHPLACE (State or foreign country) Okolona, Mississippi	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME William Moore	13b. MOTHER'S MAIDEN NAME not known	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Madge Jude	ADDRESS 4270 W. Aldine
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Glomerulonephritis			Undet.
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	II. OTHER SIGNIFICANT CONDITIONS		
ANTECEDENT CAUSES	DUE TO (b) Hypertensive Cardiovascular Disease		
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c) Undetermined		
Conditions contributing to the death but not related to the disease or condition causing death.	None		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 442X
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22. I hereby certify that I attended the deceased from **3-19**, 19**52**, to **3-27**, 19**52**, that I last saw the deceased alive on **3-27**, 1952, and that death occurred at **5:00 P** m., from the causes and on the date stated above.

23a. SIGNATURE Lakewood W Harris	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 3-31-52
(Degree or title) M. D.		

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4-4-52	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St Louis MO
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DATE RECD BY LOCAL REGISTRAR'S SIGNATURE APR 1 1952	25. FUNERAL DIRECTOR'S SIGNATURE A. L. Beal Und. O	ADDRESS 4303 Delmar
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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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed Leroy Bannister

Licensed Embalmer No. 4523

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.