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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1888-9

State File No.

FILED MAY 27 1952

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 1346

1. PLACE OF DEATH
a. COUNTY St. Louis

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo. b. COUNTY St. Louis

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Pine Lawn

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Overland City 423X

c. LENGTH OF STAY (in this place) 5-yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION Shamrock Nursing Home

d. STREET ADDRESS (If rural, give location) 2623 Woodson Road

3. NAME OF DECEASED (Type or Print)
a. (First) Clara b. (Middle) A. c. (Last) Moore

4. DATE OF DEATH (Month) (Day) (Year)
May 22, 1952

5. SEX F.

6. COLOR OR RACE W.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W.

8. DATE OF BIRTH Aug. 12, 1868

9. AGE (In years last birthday) 83
If under 1 year: Months 9 Days 10 Hours 10 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY St. Thomas

11. BIRTHPLACE (City and State or Foreign Country) Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Phillip Kamp

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE James H. Moore

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 ADDRESS
Mrs. Grace Von Steiger, 6358 Delmar Blvd.

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, asthma, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cardiovascular disease
DUE TO (c) Previous Cerebral hemorrhage
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
7 days
unknown
5 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION 4221

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)

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 Oct 15, 1947, to May 22, 1952, that I last saw the deceased alive on May 20, 1952, and that death occurred at 5 a.m., from the causes and on the date stated above.

23a. SIGNATURE Lewis Littmann MD (Degree or title)

23b. ADDRESS 8231 Clayton Rd (17)

23c. DATE SIGNED 5/22/52

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE May 24, 1952

24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery

24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

DATE REC'D BY LOCAL REG. 5-22-52

REGISTRAR'S SIGNATURE Herbert R. Donke

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
J. Donnelly 3840 Lindell Blvd.

SW (Licensed Embalmer's Statement on Reverse Side)

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

STATEMENT BY LICENSED EMBALMER

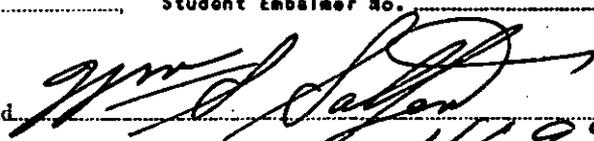
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by ~~me~~, or by me

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed _____



Licensed Embalmer No. 4699

P. O. Address St. Charles, Mo

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.