

FILED MAY 17 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17245**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 4208				
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 4-MON.		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION DePaul Hospital				e. STREET ADDRESS (If rural, give location) 1427 South 9th., Street						
3. NAME OF DECEASED (Type or Print) a. (First) Reverend Martin			b. (Middle) _____		c. (Last) Moore C.M.		4. DATE OF DEATH (Month) (Day) (Year) May 9, 1954			
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) D.		8. DATE OF BIRTH Jan. 30, 1876		9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months 3	IF UNDER 12 HRS. Days 9	Hours 	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Catholic Priest			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Perryville, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13a. FATHER'S NAME John B. Moore			13b. MOTHER'S MAIDEN NAME Emily Burgee			14. NAME OF HUSBAND OR WIFE _____				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Rev. Eugene E. M. Carthy, 1427 So. 9th., St.					
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis heart disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardiac Insufficiency DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH _____		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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 <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4200						
22. I hereby certify that I attended the deceased from Dec , 19 54 , to Apr , 19 56 , that I last saw the deceased alive on Apr 7, 1954 and that death occurred at 5:30 P.M. , from the causes and on the date stated above.										
23a. SIGNATURE (Print or Title) Walter B. Hayes - M.D.					23b. ADDRESS 901 Humboldt Bldg			23c. DATE SIGNED 5-10-54		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May 12, 1954		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.				
DATE REC'D BY LOCAL REG. MAY 11 1954		REGISTRAR'S SIGNATURE J. Carl Smith			FUNERAL DIRECTOR'S SIGNATURE Walter J. Donnelly			ADDRESS 840 Lindell Blvd.		

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.....
Signature of Student Embalmer

Signed *Francis Williamson*

Licensed Embalmer No. *35*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.