

FILED NOV 10 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35432

BIRTH NO. _____		REG. DIST. NO. 312		PRIMARY REG. DIST. NO. 544		Registrar's No. 2412			
1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Missouri b. COUNTY Ste. Genevieve					
b. CITY (If outside corporate limits, write RURAL and give town) Kirkwood, Mo.		c. LENGTH OF STAY (In this place) 3 days		c. CITY OR TOWN St. Genevieve		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital				e. STREET ADDRESS (If rural, give location) 29 Linn Drive.					
3. NAME OF DECEASED (Type or Print) a. (First) James		b. (Middle) Joseph		c. (Last) Moore		4. DATE OF DEATH (Month) (Day) (Year) Oct. 18, 1955			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Nov. 4, 1902.			
9. AGE (In years last birthday) 52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barbering		11. BIRTHPLACE (City and State or Foreign Country) Ste. Genevieve Mo.			
11. BIRTHPLACE (City and State or Foreign Country) Ste. Genevieve Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME James Moore		13b. MOTHER'S MAIDEN NAME Marie Vorst			
13a. FATHER'S NAME James Moore		13b. MOTHER'S MAIDEN NAME Marie Vorst		13c. NAME OF HUSBAND OR WIFE Agnes Moore		14. NAME OF HUSBAND OR WIFE Agnes Moore			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Nil		17. INFORMANT'S SIGNATURE OR NAME Agnes Moore		ADDRESS Ste. Genevieve Mo.			
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) Cardiac decompensation ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) increased aortic DUE TO (c) heart disease 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 type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) X		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) X		21c. (CITY, TOWN, OR TOWNSHIP) 4200 (COUNTY) (STATE)		22. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) X		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR X					
22. I hereby certify that I attended the deceased from Oct 15, 1955 to Oct 18, 1955 that I last saw the deceased alive on Oct 18, 1955 and that death occurred at 1:30 P.M. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree of title) Dr. J. B. Dombke MD				23b. ADDRESS 4761 Linn Drive		23c. DATE SIGNED 10/19/55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10-19-55		24c. NAME OF CEMETERY OR CREMATORY Valle Spring Cemetery		24d. LOCATION (City, town, or county) (State) Ste. Genevieve Mo.			
DATE REC'D BY LOCAL REG. 10-20-55		REGISTRAR'S SIGNATURE Herbert R. Dombke MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A.H. Hoppe 4704 Washington Ave.					

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 *Robert M. Murray*.....

Licensed Embalmer No. *37*.....

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.