

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

12735-63-049781
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

DO NOT WRITE ON THIS STUB
AMENDED

FILED JAN 9 1964

VS 300
Rev. 4/59

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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

| | | | |
|--|--------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | c. CITY OR TOWN <u>St. Louis</u> | |
| Length of stay in 1b <u>50yrs</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Homer G. Phillips Hosp</u> | | d. STREET ADDRESS (If outside, give location) <u>4528 Garfield Ave</u> | |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>BLANCHE MOORE</u> | | | 4. DATE OF DEATH Month Day Year <u>Dec 20 1963</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Col</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-23-1885</u> |
| 9. AGE (Last birthday) <u>78</u> | | IF UNDER 1 YEAR Months <u>8</u> Days <u>27</u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>St. Charles Mo</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U S A</u> | | 13. FATHER'S NAME <u>Henry Clay</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Georgia Lewis</u> | | 14. NAME OF HUSBAND OR WIFE <u>*</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>No</u> | |
| 17. INFORMANT <u>Perle J. Clay</u> | | Address <u>4528 Garfield Ave</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO (b) <u>Arterio Sclerotic Heart Disease</u> DUE TO (c) <u>420.0</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT - SUICIDE - HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ <u>11:50 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Nelson L Taylor, Coroner</u> | | 22b. ADDRESS <u>1300 Clark Ave.</u> | |
| 22c. DATE SIGNED <u>12-23-63</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>12-27-63</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>National</u> | | 23d. LOCATION (City, town, or country) (State) <u>Jefferson Barrack MO</u> | |
| 24. FUNERAL DIRECTOR <u>JAS H. RANDLE & SON</u> | | ADDRESS <u>3133 Bell Ave</u> | |
| 25. DATE RECD. BY LOCAL REG. <u>DEC 23 1963</u> | | 26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u> | |

USE BLACK INK OR TYPEWRITER RIBBON

15725-000-0000

FILED

3-33-1912

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

Esther N. Harris

Licensed Embalmer No. 4458

P. O. Address 4181 Washington

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.

3-33-1912