

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-049786

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12368

STATE FILE NUMBER

FILED DEC 20 1963

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis, Missouri</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis, Missouri</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
c. FULL NAME OF (If NOT in hospital, give location) <b>St. Louis City Hospital #1</b>		d. STREET ADDRESS (If outside, give location) <b>2209 DIVISION</b>	
3. NAME OF DECEASED (Type or print) <b>Willie M. Moore</b>		4. DATE OF DEATH Month <b>12</b> Day <b>11</b> Year <b>1963</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-15-17</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and state or country) <b>TONICA, MISS.</b>
13a. FATHER'S NAME <b>HAMP WILLIAMS</b>		14. NAME OF HUSBAND OR WIFE <b>WILLIE MOORE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intoxicated &amp; Brainstem compression</b> DUE TO (b) <b>Intracerebral and subarachnoid hemorrhage</b> DUE TO (c) <b>Hypertensive cardiovascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>443x</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <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.		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 <b>1515 Lafayette Avenue</b>	
21. I attended the deceased from <b>12-9-63</b> to <b>12-11-63</b> and last saw her alive on <b>12-11-63</b> Death occurred at <b>12:10 p</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <b>12-11-63</b>	
22a. SIGNATURE (Degree or title) <i>Robert J. McClain, M.D.</i>		22b. ADDRESS <b>1515 Lafayette Avenue</b>	
23b. DATE <b>12-16-63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAKDALE CEMETERY</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23d. LOCATION (City, town, or county) (State) <b>LEMAY COUNTY, MO.</b>	
24. FUNERAL DIRECTOR, ADDRESS <b>McCLAIN 1841 CASS</b>		25. DATE RECD. BY LOCAL REG. <b>DEC 14 1963</b>	
		26. REGISTRAR'S SIGNATURE <i>Ronald Smith, M.D.</i>	

USE BLACK INK OR TYPEWRITER RIBBON

**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 Wallace R. Williams

Licensed Embalmer No. 4926  
5135  
P. O. Address Hotus

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.