

REC'D JUN 9 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

16658
Do not use this space.

1. PLACE OF DEATH

(a) County.....
(b) Township.....
(c) City St. Louis, Missouri (d) Street No. BARNES HOSPITAL St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME James Moorhead

(a) Residence, No. 629 E. Vandavia St. Edwardsville, Illinois
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Moorhead

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 12/1850.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
88 2 4

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Farmer
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) Mar. 1918. 11. Total time (years) spent in this occupation 22 yrs.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unk. Ireland

13. NAME Unk. Moorhead

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT (ADDRESS) Katharine Moorhead
Edwardsville, Illinois.

18. BURIAL, CREMATION, OR REMOVAL PLACE Valhalla Crematory DATE May 18/1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Albert H. Hoppe, Inc.
429 N. Euclid Ave.

20. FILED MAY 17 1938 J. B. Budner Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-16-38 19

22. I HEREBY CERTIFY, That I attended deceased from 4-27-38, 19, to 5-16-38, 19.

I last saw him alive on 5-16-38, 19. Death is said to have occurred on the date stated above, at 3 P.M.

The principal cause of death and related causes of importance were as follows:

Ischia vesical abscess, left
Septicemia, hemolytic
streptococci
Cause of abscess unknown
non-pneumatic

Date of onset
4/1/38
5/13/38

Other contributory causes of importance:

arteriosclerosis, marked

Name of operation Drainage Date of 5/19/38

What test confirmed diagnosis? Bl. culture Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) C. H. Smith, M. D.
BARNES HOSPITAL
(Address) Edwardsville, Illinois

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

Registered Apprentice No....., working under my personal supervision.

Signed *J. G. Sullivan*

Licensed Embalmer No. *1122*

P. O. Address

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, above space should be left blank.