

REC'D MAR 13 1939

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

5045
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. 791
(b) Township Primary Registration District No. 1003
(c) City St. Louis (d) Street No. Homer G. Phillips Hospital St. 1738
(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 Robert Moore

(a) Residence, No. 2134 Division Street St. 21
(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 F 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2 - 14 - 1939

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

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo.
(STATE OR COUNTRY)

FATHER 13. NAME Robert Moore

14. BIRTHPLACE (CITY OR TOWN) Little Rock, Ark.
(STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME May Ella Stephens

16. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo.
(STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Ester May Sherard
2601 N. Whittier

18. BURIAL, CREMATION, OR REMOVAL PLACE City Cem DATE 2-24-39

19. FUNERAL DIRECTOR (NAME) She Hamilton
(ADDRESS) City Health Dept.

20. FILE 2134 J. B. Budeck
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2 - 14 - 1939

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....
I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at 9:45 A.M.
The principal cause of death and related causes of importance were as follows:

Unknown (Stillborn)

Date of onset

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

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 of injury in any way related to occupation of deceased?
If so, specify
(Signed) J. B. Budeck, M. D.
(Address) 2601 N. Whittier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

Licensed Embalmer No.....

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.