DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

AUG 11 1939 791

Registration District No. 1008

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23739

Primary Registration District No.

Registrar's No. 6012

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.

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 50 days (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis 19
(If outside city or town limits, write "RURAL")

(d) Street No. 352 N. Whittier
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME 600 John Moir

3. (b) If veteran, name war no

3. (c) Social Security No. 490-14-5541

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Nona May

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Feb. 22, 1867
(Month) (Day) (Year)

8. AGE: Years 72 Months 4 Days 14 If less than one day br. min.

9. Birthplace Philadelphia (City, town, or county) Penna (State or foreign country) 1

10. Usual occupation Floorwalker 4

11. Industry or business Dept. Store 4

FATHER
12. Name James Moir
13. Birthplace Scotland (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Frances Flinn
15. Birthplace ~~McLa~~ (City, town, or county) England (State or foreign country)

16. (a) Informant's own signature
(b) Address 352 N. Whittier St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/39 (Month) (Day) (Year)
(c) Place: burial or cremation St. Peters Cem

18. (a) Signature of funeral director A W McLaughlin
(b) Address 2301 Lafayette Ave

19. (a) JUL 8 1939 (Date received local registrar) (b) J F Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day July
year 1939 hour 9:00 minute A. M.

21. I hereby certify that I attended the deceased from 5/28/39
, 19 , to 7/6 , 19 39
that I last saw him alive on 7/6 , 19 39
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes

Due to —

Due to —

Other conditions Gangrene of extremities
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature W. Piper (M. D. or other)
Address City Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Paul C. Keith

Licensed Embalmer No. 3617

P. O. Address 2317 Lafayet

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.