

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

DEC 17 1939

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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37785

Registration District No. 1002

Primary Registration District No. _____

Registrar's No. 9624

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
4239 W. Ashland Ave.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME Ernest Moman 5570

3. (b) If veteran, name war _____ 3. (c) Social Security No. 493-10-7589

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mollie Moman 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased March 29 1883
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>7</u>	<u>9</u>	hr. _____ min. _____

9. Birthplace Greenburg, Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Porter

11. Industry or business _____

12. Name Henry Moman

13. Birthplace Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Beatrice Leaville

15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Luzene Moman

(b) Address 4239 W. Ashland

17. (a) Burial (b) Date thereof Nov. 11-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Russell Und. Co.

(b) Address 2732 Pine Street

19. (a) NOV 10 1939 (b) J. F. Bredel
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 10
(If outside city or town limits, write "RURAL")
 (d) Street No. 4239 Ashland Ave
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 8,
 year 1939 hour 6 minute 40 P.M.

21. I hereby certify that I attended the deceased from July 28,
1939, to November 8, 1939;
 that I last saw him alive on November 8, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration _____
hage
 Due to _____
 Due to _____
 Other conditions Atherosclerosis atherosclerosis
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____
 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? _____
(Specify type of place)
 Means of injury _____

23. Signature Allen P. Roe (M. D. or other) M.D.
 Address 2712 S. 14th Date signed 11/9/39

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.....

Joel Russell

Licensed Embalmer No. *4112*

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.