

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **2111**

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: Homer G Phillips  
(If not in hospital or institution, write street number or location) 1  
 (d) Length of stay: In hospital or institution 5 days  
 In this community: Unknown 2 months (Specify whether years, months or days)

8. (a) PRINT FULL NAME Daniel Moore

8. (b) If veteran, name war +  
 8. (c) Social Security No. X

4. Sex male 5. Color Col  
 6. (a) Single, widowed, married, divorced X

6. (b) Name of husband or wife ✓  
 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased 1 - 1 - 1940  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>2</u>	<u>0</u>	hr. min.

9. Birthplace St. Louis Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation +

11. Industry or business X

12. Name William Moore  
 13. Birthplace Macon Miss!  
(City, town, or county) (State or foreign country)  
 14. Maiden name Inez Stowers  
 15. Birthplace Macon Miss!  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature William Moore

(b) Address 2329 a LaSalle Street

17. (a) Burial (b) Date thereof 3 - 2 - 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Riley

(b) Address 3155 Finney Avenue

19. (a) MAR 2 1940  
(Date of local registration)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St Louis 22  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2329 a LaSalle  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1  
 year 1940 hour 12:15 minute P M.

21. I hereby certify that I attended the deceased from February 25, 1940, to March 1, 1940;  
 that I last saw h im alive on March 1, 1940;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia, secondary to inanition 6 das  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions 107a  
(Include pregnancy within 3 months of death)

Duration

6 das

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
 (a) Means of injury \_\_\_\_\_

23. Signature GE Peace (M. D. or other)  
 Address 2601 N Whittier Date signed \_\_\_\_\_

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

Rev. 5-17-39

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.

*Not embalmed  
JH*

---

---

**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.**