

Registration District No. 117

Primary Registration District No. 117

Registrar's No. 890

**REC'D MAY 15 1940**

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Webster Groves  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 454 W. Swann ave. 7  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Webster Groves  
(If outside city or town limits, write "RURAL")  
(d) Street No. 454 West Swann Ave  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Mrs ALICE CHEEK MOORE <sup>650</sup>

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Harris Royal Moore 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased February 26 - 1880  
(Month) (Day) (Year)

8. AGE: Years 60 Months 2 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace North Carolina  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

12. Name William Hayes Cheek

13. Birthplace Warren Co North Carolina  
(City, town, or county) (State or foreign country)

14. Maiden name Alice Mitter Jones

15. Birthplace Warren Co North Carolina  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John R. Luman

(b) Address 454 W. Swann Webster Groves Mo

17. (a) Cremation (b) Date thereof May 7 - 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walthalla Crematory

18. (a) Signature of funeral director Parker and Co

(b) Address Webster Groves Mo

19. (a) MAY 7 - 1940 (b) L. R. Meyers, M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6th year 1940 hour 7:30 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from May 5th, 1940, to May 6th, 1940; that I last saw her alive on May 6th and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage  
Due to Arteriosclerosis  
Due to 8701

Other conditions There were two previous strokes

Major findings: Physician  
Of operations \_\_\_\_\_

Of autopsy none  
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) (e) Means of injury \_\_\_\_\_

28. Signature Walter Smith (M. D. or other) \_\_\_\_\_  
Address Webster Groves Date signed 5/7/1940

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.

~~No Embalming~~

Signed Bob Aldrich

Licensed Embalmer No. 1332-

P. O. Address Webster Grove, Mo

**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.**