

Registration District No. 757

Primary Registration District No. 3036

Registrar's No. 165

1. PLACE OF DEATH:

(a) County St. Charles  
(b) City or town St. Charles  
(c) Name of hospital or institution:  
1018 S. Benton Avenue  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2  
(Specify whether  
In this community  
years, months or days)

3. (a) PRINT FULL NAME Annie Moore

3. (b) If veteran, name war No 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Arthur Moore 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased June 1 1878  
(Month) (Day) (Year)

8. AGE: Years 62 Months 3 Days 14 If less than one day hr. min.

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

10. Usual occupation Laundress

11. Industry or business Lindenwood College

12. Name Dave Williams

13. Birthplace St. Charles Co., Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name  
15. Birthplace Linncoln County  
(City, town, or county) (State or foreign country)

16. (a) Informant Arthur Moore

(b) Address 1018 S. Benton - St. Charles, Mo.

17. (a) Burial (b) Date thereof Sept 19-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cem., St. Charles, Mo.

18. (a) Signature of funeral director H.C. Dillinger & Sons

(b) Address 800 N. Second, St. Charles, Mo.

19. (a) 9/16/40 (b) Clarence G. Hessler  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles  
(c) City or town St. Charles  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1018 S. Benton Avenue  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 15  
year 1940 hour 11 minute 50 A.M.

21. I hereby certify that I attended the deceased from 9-22-40  
\_\_\_\_\_ 19\_\_\_\_ to 9-15-40 19\_\_\_\_;  
that I last saw her alive on 9-15-40 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death CHV. MYOCARDITIS  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions CHV. NEPHRITIS  
(Include pregnancy within 3 months of death)  
HYPERTENSION ESSENTIAL

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

23. Signature R.J. Bullock (M. D. or other) \_\_\_\_\_  
Address 207 Clay St. Date signed 10/10/40

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

MOTHER FATHER

FILED OCT 23

**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 Joseph  
Landolt....., Registered Apprentice No. 243

working under my personal supervision.

Signed John E. Dallmeier  
Licensed Embalmer No. 2951  
P. O. Address St. Charles

**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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 32957

Registration District No. 757

Primary Registration District No. 3036

Registrar's No. \_\_\_\_\_

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

**1. PLACE OF DEATH:**  
 (a) County St Charles  
 (b) City or town St Charles  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
(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** Annie Moore  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color cal 6. (a) Single, widowed, married, divorced m  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year  
 7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>3</u>	<u>14</u>	_____ hr. _____ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

15. Birthplace NOT KNOWN  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) H-5-41 Blairwood S. Messer  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month Sept day 15  
 year 1976 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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 H. Charles Mo (M. D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

SUPPLEMENTAL COPY

