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20049

FILED JUN 19 1944 318 Primary Registration District No. 1003 State File No. Registrar's No. 5025

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Mo.
(c) Name of hospital or institution: Isolation Hospital
(d) Length of stay: In hospital or institution 5-15-44-5-25-44
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(d) Street No. 2211 Carr
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Jessie Moore
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race C 6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased Mar 29 1914
8. AGE: Years 30 Months 0 Days 17 If less than one day hr. min.

9. Birthplace Marvel Ark
10. Usual occupation Domestic

11. Industry or business _____
12. Name U. S. Dawkins
13. Birthplace Unknown Ark
14. Maiden name Mary Bentley
15. Birthplace Unknown Ark

16. (a) Informant H. Buchanan
(b) Address 5600 Arsenal

17. (a) Burial (b) Date thereof 6-1-44
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Ellis Funeral Home
(b) Address 2820 Stoddard St

19. (a) JUN 1 1944 (b) J. F. Brauer
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 25 year 1944 hour 10 minute 45 a. m.
21. I hereby certify that I attended the deceased from 5-15-44 to 5-25-44
that I last saw h. ER alive on 5-25-44 and that death occurred on the date and hour stated above.

Immediate cause of death: Tuberculosis Meningitis Pulmonary Tuberculosis
Due to Tuberculosis
Other conditions: _____
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? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature W. Klingberg (M. D. or other) _____
Address 5600 Arsenal Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 L. Boy

Registered Apprentice No. my

working under my personal supervision.

Signed

L. Boy

Licensed Embalmer No. 29

P. O. Address St. Louis

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

If this body is not embalmed, fact should be so stated above.

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(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 Jessie Moore
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased May (Month) (Day) (Year)

8. AGE: Years 30 Months 0 Days 0 If less than one day..... 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..... (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....
17. (a) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)
(c) Place: burial or cremation.....
18. (a) Signature of funeral director..... (b) Address.....

19. (a) JUN 27 1944 (b) J. F. Bussack
(Date received local registration) (Registrar's signature)

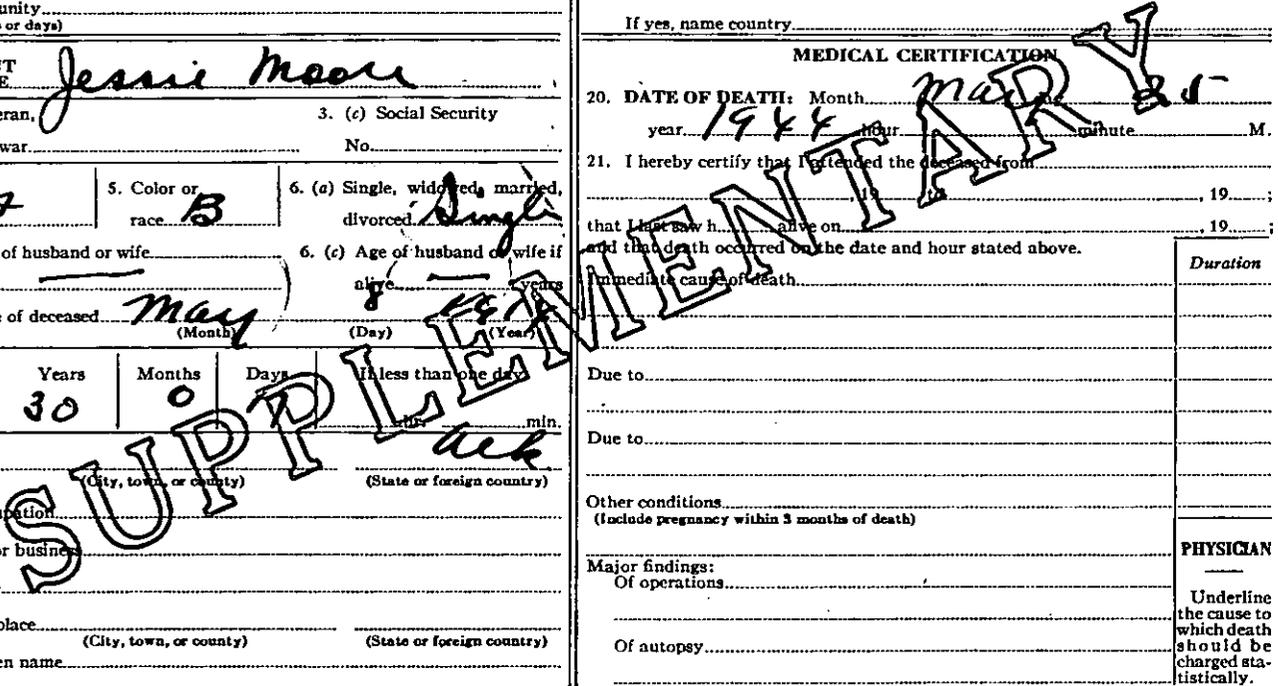
2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July year 1944 hour 11 minute 15 M.
21. I hereby certify that I attended the deceased from....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration.....
Due to.....
Due to.....
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations.....
Of autopsy.....
PHYSICIAN.....

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.....
23. Signature..... (M. D. or other).....
Address..... Date signed.....

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



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