

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **8057**
 Registrar's No. **2354**

FILED MAR 23 1945

318

Primary Registration District No. **1003**

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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3 mos. 7 days**
(Specify whether _____)
 In this community **33 years**
years, months or days

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

4. Sex *Female* **5. Color or race** *negro*
6. (a) Single, widowed, married, divorced *widow*
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased *6 9 1901*
(Month) (Day) (Year)

8. AGE:
 Years **43** Months **9** Days **3**
 If less than one day _____ hr. _____ min.

9. Birthplace *Medcalf Kentucky*
(City, town, or county) (State or foreign country)
10. Usual occupation *Domestic*

11. Industry or business _____
12. Name *John Woods*
13. Birthplace *Medcalf Kentucky*
(City, town, or county) (State or foreign country)
14. Maiden name *Lillie Hatcher*
15. Birthplace *Medcalf Kentucky*
(City, town, or county) (State or foreign country)

16. (a) Informant *Lillie Woods*
(b) Address *15 N. Beaumont*
17. (a) Burial, cremation, or removal *Greenwood* **(b) Date thereof** *3 14 45*
(Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director *Russell M. D.*
(b) Address *2732 Pine Blvd.*
19. (a) _____ (b) J. F. Meach
(Death recorded local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County _____
 (c) City or town **St. Louis,**
(If outside city or town limits, write "RURAL")
 (d) Street No. **15 N. Beaumont**
(If rural, give location)
 (e) Citizen of foreign country? **0** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **11,**
 year **1945** hour **5** minute **55 A.** M.
21. I hereby certify that I attended the deceased from **Dec.**
4, 19 **44** to **March 11,** 19 **45;**
 that I last saw her alive on **March 11,** 19 **45**
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Carcinoma of vulva, uterus, cervix with metastases to pelvic bone
 Due to **Primary in Cervix**
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) **HSA**

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) (e) Means of injury _____
23. Signature *W. B. Christian* (M. D. or _____)
 Address *2401 W. Hatcher* Date signed *3/12/45*

Duration

Undet.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 *St Louis 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, fact should be so stated above.