

1945 STANDARD CERTIFICATE OF DEATH

Registration District No. 518

Primary Registration District No. 1003

State File No. 29268

Registrar's No. 7928

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:  
4957a Washington Blvd.  
(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 Ella Moore

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

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced, widow  
6. (b) Name of husband or wife Jack N. Moore 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased September 17, 1870  
(Month) (Day) (Year)

8. AGE: Years 74 Months 10 Days 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Rome - Georgia  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

12. Name Unknown Matthews  
13. Birthplace Rome Georgia  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Julian Moore  
(b) Address Wethersfield, Connecticut

17. (a) Removal (b) Date thereof 9/10/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hoxie, Arkansas

18. (a) Signature of funeral director Albert H. Hoppe, I  
(b) Address 4700 Washington Blvd.

19. (a) SEP 10 1945 (b) J. F. Buehler  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 12  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4957a Washington Blvd.  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 8  
year 1945 hour 11 minute 23 PM

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 Pending  
Due to Arteriosclerosis

Due to 9/10/45

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) \_\_\_\_\_  
G. While at work? \_\_\_\_\_ (e). Means of injury 1/2

23. Signature Albert H. Hoppe (Physician's name)  
Address Ray, E. Date signed 9/10/45

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

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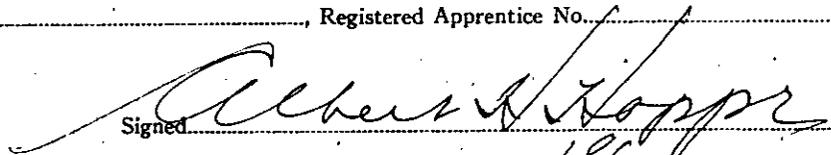
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**STATEMENT BY LICENSED EMBALMER**

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. 1861

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, fact should be so stated above.**