V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29270

FILED OCT 6 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8418

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

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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: Homer G Phillips Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 106 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 4222 Enright 9
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

19

3. (a) PRINT FULL NAME Ida Moore

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female 3

5. Color or race Negro

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife Abe Moore

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Unavailable (Month) abt (Day) 1879 (Year)

8. AGE:	Years	Months	Days	If less than one day
Abt	66			hr. min.

9. Birthplace Unavailable (City, town, or county) Ky. 1 (State or foreign country)

10. Usual occupation Retired cook

11. Industry or business

FATHER
12. Name Unavailable
13. Birthplace Unavailable (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Laura Keene
15. Birthplace Unavailable (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mary Carpenter
(b) Address 4222 Enright Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-45 (Month) (Day) (Year)
(c) Place: burial or cremation St. Peter's Cemetery

18. (a) Signature of funeral director Chas. J. Gates
(b) Address 4107 Finney Ave.

19. (a) SEP 28 1945 (Date received local registrar) (b) J. Bradach (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 26
year 1945 hour 11 minute 05 A.M.

21. I hereby certify that I attended the deceased from June 10, 1945 to Sept. 26, 1945
that I last saw her alive on Sept. 26, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Accident Decubitus Ulcers

Duration Unk

Due to

Due to

83 ac 1

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy No

PHYSICIAN
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature B. F. Murphy (M. D. or other)
Address 260 N. Whittier Date signed 9/28/45

(Licensed Embalmer's Statement on Reverse Side)

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 Thomas J. Gates, Registered Apprentice No. _____, working under my personal supervision.

Signed [signature]

Licensed Embalmer No. 4259

P. O. Address 4107 Finney Ave.

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.