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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 2 1945
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32204

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9057

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: Homer G Phillips (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St Louis
(c) City or town St Louis (If outside city or town limits, write "RURAL.")
(d) Street No. 1712 N. Newstead (If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

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3. (a) PRINT FULL NAME William Moore
3. (b) If veteran, name war ____
3. (c) Social Security No. ____
4. Sex Male
5. Color or race Col
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 1 (Month) 26 (Day) 1905 (Year)
8. AGE: Years 40 Months 8 Days 17 If less than one day ____ hr. ____ min.
9. Birthplace ____ (City, town, or county) Miss (State or foreign country)
10. Usual occupation Labor
11. Industry or business ____
MOTHER FATHER
12. Name Oscar Moore
13. Birthplace ____ (City, town, or county) Miss (State or foreign country)
14. Maiden name Mattie Reed
15. Birthplace ____ (City, town, or county) Miss (State or foreign country)
16. (a) Informant Mattie Moore
(b) Address 1712 N. Newstead
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park Cem
18. (a) Signature of funeral director J. A. Green
(b) Address 915 Franklin ave
19. (a) Oct 20 1945 (Date received local registrar) J. F. Briseck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 13 year 1945 hour 10 minute 058 M.
21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Lacerations, hemorrhage from left wound of liver and both thigh due to the hands of one Jonas Simpson (Col) at Cafe At 2110 N. Channing Ave. Ordered Due to 830 A.M. Oct. 13 1945

Duration

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations No

Of autopsy

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) Homicide
(b) Date of occurrence Oct 13 1945
(c) Where did injury occur? St Louis (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Cafe (Specify type of place)
While at work? ____ (e) Means of injury Co abor
23. Signature Alfred Moore (M. D. or other)
Address ____ Date signed 10/19/45

(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 .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed F. A. Sullen

Licensed Embalmer No. 2963

P. O. Address 2845 Franklin 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.