

STANDARD CERTIFICATE OF DEATH

State File No. _____

7777

FILED FEB 1 1946
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. _____

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 Hrs. 16 Mins
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME LaJoyce 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. 7

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

7. Birth date of deceased 1 5 46
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				<u>20 hr. 16 min.</u>

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {

12. Name Jeff Moore

13. Birthplace Greenville Mississippi
(City, town, or county) (State or foreign country)

14. Maiden name Delores Floyd

15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Walter M. Sheppard, R.D.

(b) Address 2601 N. Whittier Street

17. (a) Burial (b) Date thereof 1-24-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director V. B. Hudson

(b) Address City Health Dept

19. (a) JAN 24 1946 (b) J. F. Bredel
(Date received 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. 1503 Inge Place
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 6
year 1946 hour 12 minute 25 A.M.

21. I hereby certify that I attended the deceased from 4:09 P. M.
1 - 5 1946 to 12:25 A.M. 1-6, 1946,
that I last saw her alive on 1-6- 1946
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Premature Birth

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

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) _____
(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. H. Linker (M. D. or other) _____
Address 2601 N. Whittier Date signed 1-21-46

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

2800

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.....

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.