

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7745**

FILED FEB 20 1946
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **1518**

1. PLACE OF DEATH: **318**

(a) County **St. Louis, Mo.**

(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **7 days**
(Specify whether _____)

In this community **?**
years, months or days (Specify whether _____)

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. **4023 Cherokee** (If rural, give location) **249**

(e) Citizen of foreign country? _____ (Yes or No) **0**
If yes, name country _____

3. (a) PRINT FULL NAME **May Moorman**

3. (b) If veteran, name war **---** 3. (c) Social Security No. **---**

4. Sex **FE male** / 5. Color or race **white** 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 **Unknown**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **13th**
year **1946** hour **5:45** minute **A** M.

21. I hereby certify that I attended the deceased from **2/6/46**
to **2/13/46**, 19____, to **2/13/46**, 19____;
that I last saw h **er** alive on **2/13/46**, 19____;
and that death occurred on the date and hour stated above.

8. AGE: Years **alt 65?** Months _____ Days _____ If less than one day hr. _____ min. **7**

Immediate cause of death **Cerebro-vascular accident**

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) **9/2**

9. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____
Of autopsy _____

10. Usual occupation _____

11. Industry or business **Unknown**

MOTHER FATHER { 12. Name **Unknown** # **9**

{ 13. Birthplace (City, town, or county) # (State or foreign country)

{ 14. Maiden name # **9**

{ 15. Birthplace (City, town, or county) # (State or foreign country)

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? _____

16. (a) Informant **City Hospital Record**

(b) Address **1575 Lafayette**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **2-15-46**
(Month) (Day) (Year)

(c) Place: burial or cremation **St. Petrus**

23. Signature **R.L. Stubblefield** (M. D. or _____) **0**
Address **1420 Grattan** Date signed **2-13-46**

18. (a) Signature of funeral director **Wingbermueller**

(b) Address **3819 S. Grand**

19. (a) **FEB 13 1946** (Date received local registrar) **40**
J. F. Medeck (Registrar's signature)

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

6695

Emb separate cert filed

FEB 13 1946

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.