

V. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

11458

DEPARTMENT OF HEALTH - THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____ Primary Registration District No. 1000 Registrar's No. 2939

1. PLACE OF DEATH
(a) County St. Louis Mo.
(b) City or town St. Louis
(c) Name of hospital or institution City Hosp # 20
(d) Length of stay: In hospital or institution _____ (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County _____
(c) City or town St. Louis Mo
(d) Street No. 411 1/2 BOORMAN ST.
(e) Citizen of foreign country? NR (Yes or No) _____
If yes, name country _____

3. (a) PRINT FULL NAME Charles Moore or Charles Moore
3. (b) If veteran name war _____ 3. (c) Social Security No. _____
4. Sex Male 5. Color or race Negro
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 49 years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar day 9 year 1946 hour _____ minute 30 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.

7. Birth date of deceased _____ (Month) (Day) (Year) Apr 1906

Immediate cause of death _____
Ischemic Stenosis
Cardiac Hypertrophy
M. M. Q.

8. AGE: Years 40 Months _____ Days _____ If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____

9. Birthplace _____ (City, town, or county) (State or foreign country) week
10. Usual occupation _____ (State or foreign country) week
11. Industry or business _____ (State or foreign country) week

12. Name _____ (City, town, or county) (State or foreign country) week
13. Birthplace _____ (City, town, or county) (State or foreign country) week
14. Maiden name _____ (City, town, or county) (State or foreign country) week
15. Birthplace _____ (City, town, or county) (State or foreign country) week

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 Thos. T. O'HANRAN
(b) Address 1300 Clark St
17. (a) Anatomical Board (b) Date thereof 3-28-46 (Month) (Day) (Year)
(c) Place: burial or cremation Washington
18. (a) Signature of funeral director W. R. Rutter
(b) Address 3420 Rutledge
19. (a) MAR 28 1946 (Date received local registrar) J. Z. Bredex (Registrar's signature)

23. Signature Robert E. Jaylor (Specify type of sign) _____ (M. D. or other) _____
Address _____ Date signed 3/26/46

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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.