

7. S. No. 2  
DOM-5-43  
ev. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **18724**  
**4820**  
Registrar's No.

**FILED** JUN 13 1946  
318

1003

Registration District No. **318** Primary Registration District No.

1. PLACE OF DEATH:  
(a) County **St. Louis Mo.**  
(b) City or town **St. Louis Mo.**  
(c) Name of hospital or institution: **City Hosp - 20**  
(d) Length of stay: In hospital or institution. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo.** (b) County **St. Louis**  
(c) City or town **St. Louis**  
(d) Street No. **807 Clarkson Place**  
(e) Citizen of foreign country? (Yes or No) **No**  
If yes, name country.

3. (a) PRINT FULL NAME **Jessie Edward Moore**  
3. (b) If veteran, name war. 3. (c) Social Security No.  
4. Sex **Male** 5. Color **Negro** 6. (a) Single, widowed, married, divorced **0**  
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive **45 = 1946**  
7. Birth date of deceased. (Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **April** day **10** year **1946** hour **11** minute **10** am. M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

8. AGE: **45** Years Months Days If less than one day hr. min.  
9. Birthplace **Mo** (City, town or county) (State or foreign country)  
10. Usual occupation **Wk**  
11. Industry or business **Wk**  
12. Name **Wk**  
13. Birthplace **Wk** (City, town, or county) (State or foreign country)  
14. Maiden name **Wk**  
15. Birthplace **Wk** (City, town, or county) (State or foreign country)  
16. (a) Informant **Mrs Moore**  
(b) Address **807 Clarkson Place**  
17. (a) **Anatomical Board** Date thereof **5/17/46**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Washington**  
18. (a) Signature of funeral director **W. J. Breckner**  
(b) Address **3005 Rutledge**  
19. (a) **Anatomical Board** (Date received by) **MAY 29 1946** (Registrar's signature)

Due to **Broncho Pneumonia**  
Due to **T. M. A.**  
Other conditions (include pregnancy within 3 months of death) **107**  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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) \_\_\_\_\_ (a) Means of injury \_\_\_\_\_  
23. Signature **John E. Jugh** (M. D. or other) **3**  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

(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.

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**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.**