

No. 2
-12-45
5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15972

State File No.

FILED APR 30 1947

CORRECTED COPY
Primary Registration District No. 6076

Registrar's No. 921

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution since 3-21-47
(Specify whether
In this community 29 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2715-A Cass Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Walter J. MOODY

3. (b) If veteran, name war World War II
3. (c) Social Security No. 499-01-5764

4. Sex male 2 5. Color or race negro
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 August 9 1917
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
29 8 3
hr. min.

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

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER

12. Name unknown

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

14. Maiden name Nellie

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

16. (a) Informant Registrar, Veterans Adm. Hospital

(b) Address Jefferson Barracks, Missouri

17. (a) burial (b) Date thereof 4-19-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director Jackson Funeral Home

(b) Address 2649 Delmar, St. Louis, Missouri

19. (a) 4-20-47 (b) Charles J. Shapley
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month April day 12
year 1947 hour 12:11 minute P. M.

21. I hereby certify that I attended the deceased from
3-21-47, 19, to 4-12-47, 19;
and that death occurred on the date and hour stated above.
that I last saw him alive on 4-12-47, 19;

Immediate cause of death
HEMORRHAGE, CEREBRAL, NEPHRITIS,
CHRONIC, INTERSTITIAL WITH HYPER-
Due to TENSION AND MYOCARDIAL DAMAGE. UNK.

Due to _____

Other conditions NONE
(Include pregnancy within 3 months of death)

Major findings:
Of operations No operations

Of autopsy No autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(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 L.E. Shapley (M. D. or other)
Address Vet. Adm. Hosp., Jeff. Bks., Mo. Date signed 4-18-47

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

29-47

17
9

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

MAY 2

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.

No. 2
-12-45
5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Veterans Administration Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution since 3-21-47
(Specify whether years, months or days)

In this community 29 years
(Specify whether years, months or days)

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. 2715-A Cass Avenue
(If rural, give location)

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

3. (a) PRINT FULL NAME Walter J. Moody

3. (b) If veteran, name war World War II

3. (c) Social Security No. 499-01-5764

4. Sex male 5. Color or race negro

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 August 9, 1917
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	29	8	3	_____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Nellie

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

16. (a) Informant Registrar, Veterans Adm. Hospital

(b) Address Jefferson Barracks, Missouri

17. (a) Burial (b) Date thereof 4-19-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director Jackson Funeral Home,

(b) Address 2649 Delmar, St. Louis, Missouri

19. (a) _____ (b) Walter J. Moody
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12
year 1947 hour 12:11 minute _____ P. M.

21. I hereby certify that I attended the deceased from 3-21-47, 19, to 4-12-47, 19, and that death occurred on the date and hour stated above.

I last saw him alive on 4-12-47, 19.

Immediate cause of death HEMORRHAGE, CEREBRAL, NEPHRITIS, CHRONIC, INTERSTITIAL WITH HYPERTENSION AND MYOCARDIAL DAMAGE.

Due to _____

Due to _____

Other conditions EPILEPSY.
(Include pregnancy within 3 months of death)

Major findings:
Of operations no operations

Of autopsy no autopsy

22. If death was due to external causes, fill in the following:

(c) Accident, suicide, or homicide (specify) no

(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 L. E. Steiner (M. D. or other)

Address Vet. Adm. Hosp., Jeff. Bks., Mo. Date signed 4-14-47

Duration _____

UNK.

UNK.

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

OCT 10 1949

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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

Clare Young

Licensed Embalmer No.

3371

P. O. Address

St. Louis

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.