3. No. 2
I—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32831
Registrar's No. 9146

FILED OCT 11 1947

Registration District No. 318 — Primary Registration District No. 1003

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 6
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 days (Specify whether years, months or days)
In this community

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. 219 S Jefferson
22 (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mamie Moore
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race Col
6. (a) Single, widowed, married, divorced Wid.
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 22 (Day) 1901 (Year)
8. AGE: Years 46 Months 7 Days 3 If less than one day hr. min.
9. Birthplace Arkansas (City, town, or county) (State or foreign country)
10. Usual occupation Nil
11. Industry or business
FATHER 12. Name DICKSON ELeBy
13. Birthplace ? (City, town, or county) N.C (State or foreign country)
MOTHER 14. Maiden name SARAH
15. Birthplace ? (City, town, or county) N. C (State or foreign country)
16. (a) Informant Maudell Hallomon
(b) Address 1326 a N. 21 St
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-1-47 (Month) (Day) (Year)
(c) Place: burial or cremation GreenWood, Cem
18. (a) Signature of funeral director L. F. Walton
(b) Address 2707 STODDARD ST
19. (a) OCT 2 1947 (Date received by local registrar) (b) J. F. Breeck (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 25 year 1947 hour 11 minute 15 A M.
21. I hereby certify that I attended the deceased from Sept. 10 1947 to Sept. 25 1947 that I last saw her alive on Sept. 25 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Tuberculous Pneumonia	Undet.
Due to	
Due to	
Other conditions: Tuberculous Enteritis (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy No

PHYSICIAN — Underline the cause of 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? (Specify type of place)
While at work? Means of injury
23. Signature Oscar L Daniels (M. D. or other)
Address 2601 N Whittier Date signed 9/26/47

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

9146

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 Arthur L. Helliard

Licensed Embalmer No. 4221

P. O. Address 1154 Bayard ave

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.