

300  
10-47  
17-39  
3906

FILED OCT 9 1948  
Registration District No. **318**

Primary Registration District No. ....

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

**1. PLACE OF DEATH:**

(a) County St. Louis

(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  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 hrs. 48 min  
(Specify whether 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. 4035 Delmar  
(If rural, give location)

(e) Citizen of foreign country? 19 (Yes or No)

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Infant Moore

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Fem. 3 5. Color or race Negro

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 9 12 48  
(Month) (Day) (Year)

**8. AGE:**

|       |        |      |                       |
|-------|--------|------|-----------------------|
| Years | Months | Days | If less than one day  |
|       |        |      | <u>15 hr. 48 min.</u> |

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**

12. Name \_\_\_\_\_

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

14. Maiden name Mary Moore  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Ethel M. Shurard, M.D.

(b) Address 2601 N. Whittier

17. (a) Anatomical Board (b) Date thereof SEP 30 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director Rowland Mortuary Service

(b) Address 4104 Manchester Ave.

19. (a) SEP 30 1948 (b) J. F. Brebeck  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 9 day 12  
year 1948 hour 3 minute 50 P.M.

21. I hereby certify that I attended the deceased from 12:02 A.M.  
9-12- 1948 to 3:50 P.M. 1948,  
that I last saw her alive on 9-12- 1948,  
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**PHYSICIAN**

Duration \_\_\_\_\_

Underline the cause to 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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury 0

23. Signature W. D. Pinkles (M. D. or other) \_\_\_\_\_  
Address 2601 N. Whittier 9-22-48  
Date signed

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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.**