No. 300
10.48

FILED MAY 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17534

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4381

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

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
c. LENGTH OF STAY (In this place): 5 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Homer G Phillips Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: 1510
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
d. STREET ADDRESS (If rural, give location): 1916 N. Sarah St

3. NAME OF DECEASED (Type or Print)
a. (First): Thoma
b. (Middle): Mae
c. (Last): Moore

4. DATE OF DEATH (Month) May (Day) 14 (Year) 1949

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec 15, 1910
9. AGE (In years last birthday): 38 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Nil
11. BIRTHPLACE (State or foreign country): Arkansas
12. CITIZEN OF WHAT COUNTRY?: U S A

13a. FATHER'S NAME: Thomas Carwell
13b. MOTHER'S MAIDEN NAME: Mary Adams
14. NAME OF HUSBAND OR WIFE: Rosine Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME / ADDRESS: Rosine Moore - 1916 N. Sarah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Multiple Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: Unk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): No
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 87
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 34 V

22. *I hereby certify that I attended the deceased from* May 9, 1949, *to* May 14, 1949, *that I last saw the deceased alive on* May 14, 1949, *and that death occurred at* 8:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): O. L. Daniels, M.D.
23b. ADDRESS: 2601 N Whittier
23c. DATE SIGNED: 5-16-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 5/20-1949
24c. NAME OF CEMETERY OR CREMATORY: Washington Park Cem
24d. LOCATION (City, town, or county) (State): St Louis Mo

DATE REC'D BY LOCAL REG.: MAY 17 1949
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Boyd Bros 3706 Finney

(Licensed Embalmer's Statement on Reverse Side)

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 Henry C William, Student Embalmer No. 306, working under my personal supervision.

Student Henry C William
Student Embalmer

Signed Edward A. Flynn

Licensed Embalmer No. 4444

P. O. Address 4548 Pond

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.

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