

FILED JUL 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25137

State File No.

27271-49

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 6184

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Portageville</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis Children's Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>N.R.</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Stephen</u> b. (Middle) <u>Annae</u> c. (Last) <u>Moylan</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>14</u> (Year) <u>1949</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>5-16-49</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>1 mo 28 days</u> If under 1 year: Months _____ Days _____ If under 11 hrs: Hours _____ Min. _____
13a. FATHER'S NAME <u>Ernest Robert Moylan</u>		13b. MOTHER'S MAIDEN NAME <u>Stella Hoggard</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Ernest Moylan, Portageville, Mo.</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		11. BIRTHPLACE (State or foreign country) <u>Cape Girardeau Mo</u>	

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Ventriculitis (Brain) due to P. pyocyaneus</u>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Encephalomalacia</u> DUE TO (c) <u>Subarachnoid hemorrhage</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>820</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>332X</u>

22. I hereby certify that I attended the deceased from 6-14, 1949, to 7-14, 1949, that I last saw the deceased alive on 7-14, 1949, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u>	23b. ADDRESS <u>Childrens Hospital</u>	23c. DATE SIGNED <u>7-14-49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>7-15-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Portageville, Mo.</u>
24d. LOCATION (City, town, or county) (State)	25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe, 4700 Washington Blvd.</u>	

DATE REC'D BY LOCAL REG. <u>JUL 15 1949</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

6184

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Clement McManis

Licensed Embalmer No.

3732

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.