

FILED DEC 27 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 12787  
Registrar's No. 10785

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place) <b>5 weeks</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Missouri-Pacific Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>17- 3962a Russell</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Carrie</b> b. (Middle) <b>B.</b> c. (Last) <b>Moore</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>December 13, 1949</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Aug. 5, 1883</b>		9. AGE (In years last birthday) <b>66</b>	IF UNDER 1 YEAR Month <b>4</b> Days <b>7</b>	IF UNDER 1 HR. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Matron</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Terminal R.R. Assn.</b>		11. BIRTHPLACE (State or foreign country) <b>Memphis, Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Jake Hirsch</b>		13b. MOTHER'S MAIDEN NAME <b>Esther Lehman</b>		14. NAME OF HUSBAND OR WIFE <b>William</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Delia Massa</b> ADDRESS _____			
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) <b>Metastasis</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Myosarcoma of Corpus Uterus 2 yrs.</b> DUE TO (c) <b>Adenocarcinoma of Corpus Uterus 2 yrs.</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Partial Intestinal Obstruction</b>					INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION <b>Dec. 1948</b>	19b. MAJOR FINDINGS OF OPERATION <b>Above - Hepatosplenomegaly</b>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <b>H-8 St.</b>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>174X</b>					
22. I hereby certify that I attended the deceased from <b>Nov</b> , 19 <b>48</b> , to <b>13 Dec</b> , 19 <b>49</b> , that I last saw the deceased alive on <b>13 Dec</b> , 19 <b>47</b> , and that death occurred at <b>9:56 AM.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Royall W. Weir, M.D.</b> (Degree or title)			23b. ADDRESS <b>1755 So. Grand</b>			23c. DATE SIGNED <b>13 Dec 49</b>	
24a. BURIAL/CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Dec. 16, 1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>			
DATE REC'D BY LOCAL <b>DEC 15 1949</b>	REGISTRAR'S SIGNATURE <b>J. P. Casater</b>		FUNERAL DIRECTOR'S SIGNATURE <b>Bernard McKeen</b>		ADDRESS <b>1431 Union Blvd.</b>		

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

**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

working under my personal supervision.

Student Embalmer No. ....

Signed

Signed.....  
Student Embalmer

Licensed Embalmer No. 2950

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.