

FILED MAR 29 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10453**
Registrar's No. **2418**

BIRTH NO. _____ REG. DIST. NO. **318** - PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 11 2019	
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Bros. Hospital		d. STREET ADDRESS (If rural, give location) Michigan & Schirmer 0	

3. NAME OF DECEASED (Type or Print) Edward Moore			4. DATE OF DEATH (Month) (Day) (Year) March 12, 1951		
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	
8. DATE OF BIRTH Oct. 15, 1870		9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) 4 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (State or foreign country) St. Louis, Mo. 0	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME ? Moore		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Julia	
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. 496143879		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Anna Stein, 2629 Armand	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis heart disease		DUPLICATE			Chronic	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Intestinal Nephritis			Chronic	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input 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)	
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? 4200	

22. I hereby certify that I attended the deceased from **May 4, 1949**, to **Mar 12, 1951**, that I last saw the deceased alive on **Mar 12, 1951**, and that death occurred at **5:30 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Tom C. Wenzel M.D.		23b. ADDRESS 7702 Army Ave		23c. DATE SIGNED 3/13/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 3/15/51		24c. NAME OF CEMETERY OR CREMATORY Mt. Olive	
24d. LOCATION (City, town, or county) (State) Lemay 23, Mo.					

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAR 14 1951		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS XXXXXXXX Fendler Und. Co., 7420 Mich.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEB 7 4 1937

[Handwritten signature]

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.....

W. E. Morris

Signed.....

Student Embalmer

Licensed Embalmer No. **3360**

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.