

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18400**
Registrar's No. **5174**

FILED JUN 15 1951

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **10034**

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, Missouri	c. LENGTH OF STAY (in this place) 7 wks.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2059	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If rural, give location) 5622 Delmar Blvd.	

3. NAME OF DECEASED (Type or Print) a. (First) Edgar b. (Middle) Marshall c. (Last) Moorman	4. DATE OF DEATH (Month) (Day) (Year) June 4 1951
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 12, 1908	9. AGE (In years last birthday) 42 IF UNDER 1 YEAR: Months Days IF UNDER 14 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Worker	10b. KIND OF BUSINESS OR INDUSTRY Pub. Welfare	11. BIRTHPLACE (State or foreign country) Grand Rivers, Ky.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME William C. Moorman	13b. MOTHER'S MAIDEN NAME Nancy C. Meyers	14. NAME OF HUSBAND OR WIFE Mamie Moorman
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or date of service) Yes WW II	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mamie N. Moorman, 5622 Delmar
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lymphosarcoma		
	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	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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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? 1981
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22. I hereby certify that I attended the deceased from **4/13**, 19 **51**, to **6/4**, 19 **51**, that I last saw the deceased alive on **6/4**, 19 **51**, and that death occurred at **8:15A** m., from the causes and on the date stated above.

23a. SIGNATURE R. Bradley	(Degree or title) 0 M.D.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 6/4/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6-6-51	24c. NAME OF CEMETERY OR CREMATORY Ellington, Mo.	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. JUN 5 1951	REGISTRAR'S SIGNATURE J. B. Carter	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*Wm
Giles*

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

J Wm D entler

Signed.....
Student Embalmer

Licensed Embalmer No. *365B*

P. O. Address *St Louis Mo*

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.