

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **14584**
 Registrar's No. **3432**

LED MAY 1 - 1952

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. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SAINT LOUIS		2219			
d. FULL NAME OF HOSPITAL OR INSTITUTION HOMER G. PHILLIPS HOSPITAL			d. STREET ADDRESS (If rural, give location) 3217 LAWTON					
3. NAME OF DECEASED (Type or Print) a. (First) Charlsie b. (Middle) Ann c. (Last) Moore			4. DATE OF DEATH (Month) (Day) (Year) April 8 1952					
5. SEX F. 3	6. COLOR OR RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH MARCH 12, 1901	9. AGE (In years last birthday) -51	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 MO. Hours	IF UNDER 1 MO. Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BEAUTICIAN		10b. KIND OF BUSINESS OR INDUSTRY OWN		11. BIRTHPLACE (City and State or Foreign Country) MARIANA ARKANSAS		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13a. FATHER'S NAME WALSH JOHNSON		13b. MOTHER'S MAIDEN NAME JOSEPHINE JACKSON		14. NAME OF HUSBAND OR WIFE MACK 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 EDDIE MAE SHORT				
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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Cervix ANTECEDENT CAUSES DUE TO (b) Undetermined DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None					INTERVAL BETWEEN ONSET AND DEATH Undet.		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			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)				
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? 171X				
22. I hereby certify that I attended the deceased from 3-13 , 19 52 , to 4-8 , 19 52 , that I last saw the deceased alive on 4-8 , 19 52 , and that death occurred at 4:30a m., from the causes and on the date stated above.								
23. SIGNATURE Charlene M. Turner (Degree or title) M. D.				23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 4-8-52		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 4-14-52	24c. NAME OF CEMETERY OR CREMATORY NATIONAL		24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO.			
DATE REC'D BY LOCAL REG. APR 11 1952		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. GENERAL DIRECTOR'S SIGNATURE E. B. Komer		ADDRESS 1221 N. GRAND		

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Charles Croesus

Licensed Embalmer No. 4758

P. O. Address 1221 N Grand

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.