

STANDARD CERTIFICATE OF DEATH

State File No. 43662

11539

FILED JAN 10 1953

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

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 OR TOWN) St. Louis		c. LENGTH OF STAY (in this place)	
c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		d. STREET ADDRESS (If rural, give location) 5 5875 Cabanne Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospt.		5 5875 Cabanne Ave.	
3. NAME OF DECEASED (Type or Print) Katherine Moore		4. DATE OF DEATH (Month) (Day) (Year) Dec. 13 1952	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married		8. DATE OF BIRTH Mar. 28 1878	
9. AGE (In years last birthday) 74		10. UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) St. James Mo.		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Michael Moore		13b. MOTHER'S MAIDEN NAME Katherine Hartnett	
14. NAME OF HUSBAND OR WIFE			
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. None	
17. INFORMANT'S SIGNATURE OR NAME Mrs Anna Beck		ADDRESS 5875 Cabanne Ave	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of esophagus 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. none	
INTERVAL BETWEEN ONSET AND DEATH don't know.			
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)			
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?		150X	
22. I hereby certify that I attended the deceased from 10-27-52, 19__, to 12-13-52, 19__, that I last saw the deceased alive on 12-13-52, 19__, and that death occurred at 5:15 P.M., from the causes and on the date stated above.			
23a. SIGNATURE Walter Hoerlman MD		23b. ADDRESS 1506 St. Louis Avenue	
23c. DATE SIGNED 12-15-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/16/52	
24c. NAME OF CEMETERY OR CREMATORY Calvary Cem.		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL REG. DEC 15 1952		REGISTRAR'S SIGNATURE J. Clark Smith MD	
25. FUNERAL DIRECTOR'S SIGNATURE Jos. W. Clark		ADDRESS 1125 Hodiamont Ave.	

(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 *John J. Haines*

Licensed Embalmer No. *4108*

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.