

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16027

State File No.

4370

DECEASED MAY 14 1953

318

1003

Registrar's No.

BIRTH NO. REG. DIST. NO. PRIMARY REG. DIST. NO.

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

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 town) St. Louis	c. LENGTH OF STAY (In this place) township)	c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2209	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 20 - 2712 Howard 0	

3. NAME OF DECEASED (Type or Print) a. (First) Willie	b. (Middle)	c. (Last) Moore	4. DATE OF DEATH (Month) (Day) (Year) April 24 1953
5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single 0	8. DATE OF BIRTH April 20, 1888
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hod Carrier	11. BIRTHPLACE (State or foreign country) Macon, Miss. /
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME Joe Moore	13b. MOTHER'S MAIDEN NAME Lizzie Patterson	14. NAME OF HUSBAND OR WIFE None
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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. 305-07-1115	17. INFORMANT'S SIGNATURE OR NAME Lest Moore	ADDRESS 1445 Falling Springs Rd
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis, Far Advanced (Military)		
	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. Meningitis, Tuberculosis		Undet.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 002X
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22. I hereby certify that I attended the deceased from 3-1, 19 53, to 4-24, 19 53, that I last saw the deceased alive on 4-24, 19 53, and that death occurred at 5:30p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Roy J. Williams M. D. 0	23b. ADDRESS 2601 N Whittier St.	23c. DATE SIGNED 4-27-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4-29-53	24c. NAME OF CEMETERY OR CREMATORY Booker Washington	24d. LOCATION (City, town, or county) (State) E. St. Louis, Ill.
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DATE REC'D BY LOCAL REG. APR 28 1953	REGISTRAR'S SIGNATURE C. B. Koone	25. FUNERAL DIRECTOR'S SIGNATURE C. B. Koone	ADDRESS 1221 N. Grand
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(Licensed Embalmer's Statement on Reverse Side)

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 C. Croano

Licensed Embalmer No. 4755

P. O. Address 1271 N. Main

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.