

FILED SEP 21 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32037

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8168**

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) \_\_\_\_\_  
c. CITY OR TOWN **St. Louis** d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION **BARNES HOSPITAL** No. STREET ADDRESS (If rural, give location) **5 5948 Cates Ave**

3. NAME OF DECEASED a. (First) **AMMA** b. (Middle) **B.** c. (Last) **MOORE** 4. DATE OF DEATH (Month) (Day) (Year) **Sept. 3 1954**

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, **Widowed** 8. DATE OF BIRTH **April 1 1873** 9. AGE (in years last birthday) **81** IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **house wife** 10b. KIND OF BUSINESS OR INDUSTRY **at home** 11. BIRTHPLACE (City and State or Foreign Country) **Valparaiso, Indiana U.S.A.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **Benjamin Pennock** 13b. MOTHER'S MAIDEN NAME **Nancy MacCormick** 14. NAME OF HUSBAND OR WIFE **Frank C. Moore**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) **no** (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. **none** 17. INFORMANT'S SIGNATURE OR NAME **Mrs. Lois Gray, Chincoteague, Va.** ADDRESS \_\_\_\_\_

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) **Congestive heart failure** INTERVAL BETWEEN ONSET AND DEATH **abt. 1 mo.**

ANTECEDENT CAUSES  
\*This does not mean the mode of dying, such as heart failure, asthemia, etc. It means the disease, injury, or complication which caused death.  
Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) **Arteriosclerotic Heart Disease** **sev. years**

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.  
DUE TO (c) \_\_\_\_\_

19a. DATE OF OPERATION \_\_\_\_\_ 19b. MAJOR FINDINGS OF OPERATION \_\_\_\_\_ 20. AUTOPSY? YES  NO

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  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR \_\_\_\_\_ **4200**

22. I hereby certify that I attended the deceased from **8-25**, 19**54**, to **9-3**, 19**54**, that I last saw the deceased alive on **9-3**, 19**54**, and that death occurred at **4:10p** m., from the causes and on the date stated above.

23a. SIGNATURE **G. P. Vermillion, M.D.** (Degree or title) **M.D.** 23b. ADDRESS **BARNES HOSPITAL** 23c. DATE SIGNED **9-4-54**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 24b. DATE **9-7-54** 24c. NAME OF CEMETERY OR CREMATORY **Valhalla Cemetery** 24d. LOCATION (City, town, or county) (State) **St. Louis County Mo.**

DATE REC'D BY LOCAL REG. **SEP 7 1954** REGISTRAR'S SIGNATURE **Carl Smith** 25. FUNERAL DIRECTOR'S SIGNATURE **Mr. E. R. Lupton & Sons** ADDRESS **7233 Delmar**  
(Licensed Embalmer's Statement on Reverse Side)

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

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**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.....  
Signature of Student Embalmer

Signed *Clarence H. Murray*

Licensed Embalmer No. *401*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.