

FILED JUN 22 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20257

State File No.

318

1003

Registrar's No. 5070

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		REGISTRAR'S NO. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>St Louis</u>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>St Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>5074 MAPLE AVE</u>				STREET ADDRESS (If rural, give location) <u>5074 MAPLE AVE</u> ²¹²⁹				
3. NAME OF DECEASED (Type or Print) a. (First) <u>MRS AMELIA ELIZABETH</u> b. (Middle) _____ c. (Last) <u>MOORE</u>			4. DATE OF DEATH (Month) <u>6</u> (Day) <u>8</u> (Year) <u>1955</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>3-18-1910</u>		
9. AGE (In years last birthday) <u>45</u>		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) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>St Louis, MO.</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>JAMES GRAHAM</u>			13b. MOTHER'S MAIDEN NAME <u>MARY KIRK</u>		14. NAME OF HUSBAND OR WIFE <u>MR FRANK MOORE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY # _____		17. INFORMANT'S SIGNATURE OR NAME <u>Jack Moore</u> ADDRESS <u>5074 MAPLE</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocarditis - Acute</u> ANTECEDENT CAUSES <u>Endocarditis.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Ischio-rectal Abscess in MARCH 1955.</u>					INTERVAL BETWEEN ONSET AND DEATH _____	
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) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>4214</u>				
22. I hereby certify that I attended the deceased from <u>3-29-1955</u> , to <u>June 8, 1955</u> , that I last saw the deceased alive on <u>6/8-1955</u> , and that death occurred at <u>10:30</u> m., from the causes and on the date stated above.								
23a. SIGNATURE <u>Wain M. Carter</u>			(Degree or title) <u>M. D.</u>		23b. ADDRESS <u>2605 Franklin St. Louis 6 Mo.</u>		23c. DATE SIGNED <u>6-10-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>6-13-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD</u>		24d. LOCATION (City, town, or county) (State) <u>St Louis Co Mo.</u>		
DATE REC'D BY LOCAL REG. <u>JUN 11 1955</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Bennie Love</u> ADDRESS <u>3103 Washington</u>			

JUN 11 1955

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE 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.....
Signature of Student Embalmer

Signed *H. Claude Good*

Licensed Embalmer No. *34*

P. O. Address *45756*

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.