

FILED SEP 1 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27985

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6730

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo.		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place) 3-mon		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Baptist Hospital		STREET ADDRESS (If rural, give location) 12 4515 Lindell Blvd.		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) Margaret K. Moore		4. DATE OF DEATH Aug. 2, 1955			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S.	8. DATE OF BIRTH Aug. 26, 1905	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months 11 Days 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) So. Am. Rep. Braniff Int. Airways		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Ill.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Henry Moore		13b. MOTHER'S MAIDEN NAME Margaret Kennedy	
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. 489-03-8533	
17. INFORMANT'S SIGNATURE OR NAME Miss Alice M. Moore		ADDRESS 4515 Lindell Blvd.			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>metastatic adenocarcinoma</i> ANTECEDENT CAUSES from Left Breast Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>from Left Breast</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Pathological fracture Rt. Hip</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 1/6 mos</i>	
19a. DATE OF OPERATION <i>Apr 19 1955</i>		19b. MAJOR FINDINGS OF OPERATION <i>Radical mastectomy April 19 55</i>		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) <i>170X F</i>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Apr 19 1955</i> , to <i>Aug 2 1955</i> , that I last saw the deceased alive on <i>Aug 2 1955</i> , and that death occurred at <i>9:27 p.m.</i> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <i>A. K. Dalton M.D.</i>		23b. ADDRESS <i>4500 Olive St. St. Louis</i>		23c. DATE SIGNED <i>Aug 5 55</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug. 4, 1955		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24d. LOCATION (City, town, or county) (State) Villa Ridge, Ill.		DATE REC'D BY LOCAL REG. AUG 3 1955		REGISTRAR'S SIGNATURE <i>Carl Smith</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur J. Donnelly</i>		ADDRESS 3810 Lindell Blvd.		(Licensed Embalmer's Statement on Reverse Side)	

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

0.300
0.48

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: *Francis Williams*

Licensed Embalmer No. *388*

P. O. Address *3840 7*

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.