No. 300
10.48

FILED JAN 29 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2958

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 260

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 01 3313 a Franklin ave 2219
e. STREET ADDRESS (If rural, give location): 3313 a Franklin ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐

3. NAME OF DECEASED (Type or Print)
a. (First): Walter
b. (Middle):
c. (Last): Moore

4. DATE OF DEATH (Month) (Day) (Year): Jan 6. 1957

5. SEX: Male 2
6. COLOR OR RACE: Col
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug 16. 1894
9. AGE (In years last birthday): 62 | 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): Labor
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and State or Foreign Country): Miss
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: William Moore
13b. MOTHER'S MAIDEN NAME: Maggie Red.
14. NAME OF HUSBAND OR WIFE: Fannie Moore

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.: —
17. INFORMANT'S SIGNATURE OR NAME: Dan Moore 3313 a Franklin ave ADDRESS

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): Oavernoma of Lungs — INTERVAL BETWEEN ONSET AND DEATH: ?

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. 163 x

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? 2 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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/28, 1956, *to* 1/6, 1957, *that I last saw the deceased alive on* 1/6, 1957, *and that death occurred at* 6 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): D. E. Taylor MD
23b. ADDRESS: 3136 Choutaw
23c. DATE SIGNED: 1/9/57

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Jan 11/57
24c. NAME OF CEMETERY OR CREMATORY: Washington Park Cem
24d. LOCATION (City, town, or county): St Louis (State): Mo

DATE REC'D BY LOCAL REG.: JAN 10 '57
REGISTRAR'S SIGNATURE: J Earl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE: F. A. Green 4214 Delmar ADDRESS

(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 embal

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed F. A. Gilen

Licensed Embalmer No 2963

P. O. Address 4214 Delman

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fail 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.