

THE DIVISION OF HEALTH OF MISSOURI
 FILED NOV 22 1957 STANDARD CERTIFICATE OF DEATH

42382

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11001**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ILLINOIS b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR St. Louis, Missouri		c. LENGTH OF STAY (In this place)	
c. CITY (If outside corporate limits, write RURAL and give township) OR Granite City 812 ⁰		d. STREET ADDRESS (If rural, give location) 32 1929 St. Clair Avenue.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 14 Jewish Hospital		4. DATE OF DEATH (Month) (Day) (Year) 11 - 14 - 57	
3. NAME OF DECEASED (Type or Print) a. (First) KEVIN b. (Middle) LEROY c. (Last) MOORE		5. SEX MALE 6. COLOR OR RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	
8. DATE OF BIRTH 11-14-57		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 12 HRS. Hours Min. 11 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME GEORGE EDWARD MOORE SR.		13b. MOTHER'S MAIDEN NAME Dorothy M. Wiggins	
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. NONE		17. INFORMANT'S SIGNATURE OR NAME GEORGE E. MOORE SR. ADDRESS 1929 St. Clair Granite City ILLINOIS	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) respiratory insufficiency ANTECEDENT CAUSES DUE TO (b) atelectasis - DUE TO (c) prematurity? 762.5 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetic mother - Caesarian Sect.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 11-14, 1957 , to 11-14, 1957 , that I last saw the deceased alive on 11-14, 1957 , and that death occurred at 7:38 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Carl Maltick M.D.		23b. ADDRESS Jewish Hospital	
23c. DATE SIGNED 11/14/57		24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	
24b. DATE 11-15-1957		24c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery	
24d. LOCATION (City, town, or county) (State) Granite City, Illinois		25. FUNERAL DIRECTOR'S SIGNATURE Frank Messer ADDRESS Granite City Ill	
DATE REC'D BY LOCAL REG. NOV 18 57		REGISTRAR'S SIGNATURE Carl Smith	

WRITE PLAINLY—USING UNFADEING 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
Student Embalmer

Signed: *Charles E Mercer*

Licensed Embalmer No. *2988*

P. O. Address *Asaute City Ill*

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.