Health, Welfare Public Service

300
1-56

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH 35231-58

58-019969
STATE FILE NUMBER

FILED JUN 11 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5441

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, give TOWNSHIP only) OR TOWN St.Louis — Inside Limits Yes X No ☐

c. CITY OR TOWN St.Louis — Inside Limits Yes X No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION Cardinal Glennon — Length of stay in lb 4 days

d. STREET ADDRESS (If outside, give location) 2858 Belt Ave. — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First Linda Middle Lou Last Moore

4. DATE OF DEATH Month 51 Day 22 Year 58

5. SEX F

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 5-18-58

9. AGE (In years last birthday) — IF UNDER 1 YEAR Months Days 4 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no

10b. KIND OF BUSINESS OR INDUSTRY no

11. BIRTHPLACE (City and state or country) St.Louis Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Donald Moore

14. MOTHER'S MAIDEN NAME Patricia Ammons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. no

17. INFORMANT Donald Moore Address 2858 Belt Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Low Birth Weight 3 lbs 7 oz.
DUE TO (c) Twin Birth

O.K. Jack [illegible] Deputy Coroner 5/26/58

INTERVAL BETWEEN ONSET AND DEATH 3days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 760.5

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 5/22/58, to 5/22/58 and last saw her alive on 5/22/58
Death occurred at 5:30P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John B. Summers (Degree or title) MD

22b. ADDRESS 1465 S. Grand

22c. DATE SIGNED 5/23/58

23a. BURIAL, CREMATION, REMOVAL (Specify) burial

23b. DATE 5-24-1958

23c. NAME OF CEMETERY OR CREMATORY Mt.Lebanon Cemetery

23d. LOCATION (City, town, or county) St.Louis (State) Missouri

24. FUNERAL DIRECTOR Arthur J. Donnelly ADDRESS 3840 Lindell Blvd.

25. DATE RECD. BY LOCAL REG. MAY 23 58

26. REGISTRAR'S SIGNATURE J. Earl Smith MD MFB

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 46

P. O. Address 38 [illegible]

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