Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-030777
STATE FILE NUMBER

FILED AUG 28 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7967

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: St. Louis City Hosp. #1 — Length of stay in 1b: 25 0
d. STREET ADDRESS (If outside, give location): 916 Lafayette Ave — Reside on Farm: Yes [ ] No [X]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY: /
c. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 239 0

3. NAME OF DECEASED (Type or print): First: Ben — Middle: E. — Last: Moran

4. DATE OF DEATH: Month: Aug — Day: 14 — Year: 58

5. SEX: Male 0

6. COLOR OR RACE: White

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] 2 **DIVORCED** [ ]

8. DATE OF BIRTH: Oct 19 1888

9. AGE (In years last birthday): 69 — 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): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (City and state or country): Perryville, Mo 0

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

13a. FATHER'S NAME: -- Moran

13b. MOTHER'S MAIDEN NAME: Not known

14. NAME OF HUSBAND OR WIFE: Margaret

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

16. SOCIAL SECURITY NO.: 494-07-7045

17. INFORMANT: Gilbert Moran — Address: 4205 Detonty

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Saddle embolus
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 420.0

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

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 7-30-58, to 8-14-30 and last saw him alive on 8-14-30
Death occurred at 8:20 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE W. Leighton MD (Degree or title)

22b. ADDRESS: 1515 Lafayette Ave.

22c. DATE SIGNED: 8-14-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Aug 16 1958

23c. NAME OF CEMETERY OR CREMATORY: S.S.Peter & Paul Cem.

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

24. FUNERAL DIRECTOR: J.L.Ziegenhein & Sons — ADDRESS: 2027 Gravois Ave

25. DATE RECD. BY LOCAL REG.: AUG 16 '58

26. REGISTRAR'S SIGNATURE: J Earl Smith MD Acm

(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 embalmed by me, or by ....., Student Embalmer No. ..... working under my personal supervision.

Student ..... Signed E. P. Kidwell

Signature of Student Embalmer

Licensed Embalmer No. 3877

P. O. Address 7027 Grava

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.