

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034523  
STATE FILE NUMBER

FILED OCT 10 1958

Registration District No. 318

318

Primary Registration District No. 1003

1003

Registrar's No. 9430

9430

300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		c. CITY OR TOWN <b>St. Louis, Mo.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
5. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hosp.</b>		Length of stay in lb <b>82yrs.</b>	
23		d. STREET ADDRESS (If outside, give location) <b>4017 Lexington</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Moran</b> Last <b>Moran</b>			4. DATE OF DEATH Month <b>September</b> Day <b>30</b> Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 13, 1876</b>
9. AGE (In years at birthday) <b>82</b>		10. UNDER 1 YEAR Months <b>2</b> Days <b>10</b> Hours <b>0</b> Min. <b>0</b>	11. UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13a. FATHER'S NAME <b>Charles Henry</b>		13b. MOTHER'S MAIDEN NAME <b>Catherine Sweeney</b>	14. NAME OF HUSBAND OR WIFE <b>Charles Moran</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	17. INFORMANT <b>Gertrude Bell</b> Address <b>4017 Lexington Ave.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute hemorrhagic pancreatitis</b> DUE TO (b) <b>multiple fractures legs &amp; arms</b> DUE TO (c) <b>obesity obesity</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c) <b>obesity obesity</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>fell on linoleum</b>		
20c. TIME OF INJURY Hour <b>9</b> Month <b>9</b> Day <b>13</b> Year <b>1958</b> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <b>ST. Louis Mo</b> COUNTY <b>St. Louis</b> STATE <b>MO</b>		
21. I attended the deceased from <b>6:30 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Thos. J. Wailer</b> (Degree or title) <b>M.D.</b>		22b. ADDRESS <b>634 N. Grand</b>	
22c. DATE SIGNED <b>10-2-58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10/3/1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
24. FUNERAL DIRECTOR <b>Morrell Funeral Home</b> ADDRESS <b>3710 N. Grand</b>		25. DATE RECD. BY LOCAL REG. <b>OCT 2 '58</b>	26. REGISTRAR'S SIGNATURE <b>Charles Smith Mo</b>

MEDICAL CERTIFICATION  
USE ONLY BLACK-INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.  
Doctor, coroner, etc., must use only standard nomenclature in Part I. NO symptoms will be listed.

Injured: fell on linoleum

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 *Laron E. Percy* .....

Licensed Embalmer No. *4094* .....  
P. O. Address: *St. Louis,* .....

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.