

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041991

STATE FILE NUMBER

1958 DEC 9

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 11338

300
-57

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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 4121 Fairfax	
3. NAME OF DECEASED (Type or print) John		4. DATE OF DEATH Month 11 Day 22 Year 58	
5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH John 23-1883 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME John W. Moody Sr.		13b. MOTHER'S MAIDEN NAME Mary Dement	
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. 857-09-4990A	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Menia</u>		17. INFORMANT Gertrude Madison 4121 Fairfax	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Atherosclerotic nephrosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH undet.	
DUE TO (c) <u>446 X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Menic Colitis; A. S. H. D.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year o.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>11-10-58</u> to <u>11-22-58</u> and last saw <u>xx</u> him alive on <u>11-22-58</u> Death occurred at <u>9:07</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>S. A. Inaser</u> (Degree or title), M.D.		22b. ADDRESS 2601 Whittier Street	
		22c. DATE SIGNED 11-24-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem</u>	23b. DATE <u>11-26-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park Cem</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>
24. FUNERAL DIRECTOR <u>Manuel Und Co. 1711 N. Taylor</u>		25. DATE RECD. BY LOCAL REG. <u>NOV 25 '58</u>	
		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *M. Claude Gordon*

Licensed Embalmer No. *3489*

P. O. Address *4575 Alld*

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.