

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-041994

STATE FILE NUMBER

FILED NOV 20 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10651

300  
-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>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis,</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP.</b>		Length of stay in 1b <b>#1.</b>	d. STREET ADDRESS (If outside, give location) <b>2229 2704 Caroline Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle Last <b>MOORE</b>			4. DATE OF DEATH Month <b>NOV.</b> Day <b>4,</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 type="checkbox"/> <b>3</b> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3-4-1873</b>
9. AGE (In years last birthday) <b>85</b>		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) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Jefferson City, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13a. FATHER'S NAME <b>Phillip Schmidt</b>	13b. MOTHER'S MAIDEN NAME <b>Augusta Wagoner</b>
14. NAME OF HUSBAND OR WIFE <b>James A. Moore, Sr.</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>	16. SOCIAL SECURITY NO. <b>None</b>
17. INFORMANT <b>James A. Moore Jr. 3142 Lackland 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>adenocarcinoma of rectum</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>hepatic &amp; pulmonary metastasis</b> DUE TO (c) <b>metastasis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>generalized arteriosclerosis.</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 yr.</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input 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>154x</b>		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT <input 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 <b>Jefferson City, Missouri</b>		20g. COUNTY STATE	
21. I attended the deceased from <b>8-21-58</b> to <b>11/4/58</b> and last saw her/him alive on <b>11/4/58</b> Death occurred at <b>7:05 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Do not write title) <b>Joseph F. Cannon M.D.</b>	
22b. ADDRESS <b>1515 LAFAYETTE AVE</b>		22c. DATE SIGNED <b>11/5/58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>11-6-58</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Jefferson City, Missouri</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <b>Beiderwieden F.H.Inc. 1936 St.Louis Ave.</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 6 '58</b>	
26. REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b>		27. REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b>	

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 *[Handwritten Signature]*

Licensed Embalmer No. 4520  
P. O. Address, *[Handwritten Address]*

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.