Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 59-003301

FILED JAN 28 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 422

1. PLACE OF DEATH
a. COUNTY City of St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Frisco Emp. Hosp — Length of stay in Ib 66 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Ft. Scott, b. COUNTY Kansas
c. CITY OR TOWN Ft. Scott — Inside Limits Yes [X] No [ ]
8150 S STREET ADDRESS (If outside, give location) 102 S. Barbee — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First HARRY Middle D. Last MOORE
4. DATE OF DEATH Month Jan Day 12 Year 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] / DIVORCED [ ]
8. DATE OF BIRTH Oct.12,1884
9. AGE (In years last birthday) 74 — 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) Engineer
10b. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (City and state or country) Indiana
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Henry Moore
13b. MOTHER'S MAIDEN NAME Jeanette Williams
14. NAME OF HUSBAND OR WIFE Rose Moore
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. unknown
17. INFORMANT Rose Moore Address 102 S.Barbee Ft.Scott,Kansas

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) Myelogenous leukemia — INTERVAL BETWEEN ONSET AND DEATH 2 1/2 Mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 204.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

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 8 Nov 58, to 12 Jan 59 and last saw her/him alive on 11 Jan 59
Death occurred at 12:30 p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Wm D Schirmer M.D. (Degree or title)
22b. ADDRESS 4960 Lacleede
22c. DATE SIGNED 1/12/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 1-13-59
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State) Fort Scott, Kansas

24. FUNERAL DIRECTOR Albert H. Hoppe ADDRESS 4700 Washington, Blvd.
25. DATE RECD. BY LOCAL REG. JAN 13 59
26. REGISTRAR'S SIGNATURE Paul Smith MD M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

APR 24 19[illegible]

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 .....

Licensed Embalmer No. 3653

P. O. Address St. Louis, Mo.

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.