

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011213

STATE FILE NUMBER

2 3146

Health, Welfare
Public
Service

300
1-57
2

FILED APR 10 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis, Mo		c. CITY OR TOWN St Louis, Mo.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Community Hospital		d. STREET ADDRESS (If outside, give location) 4532 Kennerly Ave	
3. NAME OF DECEASED (Type or print) First Irma Middle Moorman Last		4. DATE OF DEATH Month 3 Day 26 Year 59	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-29-1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Henderson Ky.
12. CITIZEN OF WHAT COUNTRY? U.S. A.		13a. FATHER'S NAME George Rankin	
13b. MOTHER'S MAIDEN NAME Sallie Beverly		14. NAME OF HUSBAND OR WIFE Glover Moorman	
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. NO	17. INFORMANT Glover Moorman Address 34532 Kennerly Av
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic COMA DUE TO (b) Carcinoma of Liver DUE TO (c) Carcinoma of Rectum PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 154X			INTERVAL BETWEEN ONSET AND DEATH 3 days 4 mos 9 mos
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.)	
20c. TIME OF INJURY Hour _____ a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 October 1958, March 1959 and last saw her alive on March 26, 1959 Death occurred at 4:10 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Do not write in title) Cecil Sweed J. Gaffney, M.D.		22b. ADDRESS 2066 N. Kingshighway	22c. DATE SIGNED March 28, 1959
23a. BURIAL, CREMATION, REMOVAL Removal	23b. DATE 4-1st-59	23c. NAME OF CEMETERY OR CREMATORY Washington Park	23d. LOCATION (City, town, or county) (State) St Louis, Mo 1959
24. FUNERAL DIRECTOR A. L. Beal Und. Co 4303 Delmar		25. DATE RECD. BY LOCAL REG. MAR 30 '59	26. REGISTRAR'S SIGNATURE Loard Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be traced. All diseases in Part I must be causally related.

m g. ca.

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 *G. D. Richardson*

Licensed Embalmer No. *2928*

P. O. Address *2625 Glen*

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.