

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020007  
STATE FILE NUMBER

Health,  
& Welfare  
Public  
Service

FILED JUN 2 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1390

3. 300  
1-57

191  
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Koch</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Robert Koch Hosp.</u>		Length of stay in 1b <u>365 days</u>	d. STREET ADDRESS (If outside, give location) <u>2604 N. Leffingwell</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mardell</u> Middle Last <u>Moore</u>			4. DATE OF DEATH Month <u>5</u> Day <u>15</u> Year <u>59</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-6-18</u>	9. AGE (In years last birthday) <u>41</u>	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) <u>Presser</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Ernest Wiggins</u>		13b. MOTHER'S MAIDEN NAME <u>Ella Peterson</u>		14. NAME OF HUSBAND OR WIFE <u>Willie Moore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	17. INFORMANT Address <u>Robert Koch Hospital, Koch, Mo.</u>		
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>Spontaneous Pneumothorax, Right</u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Pulmonary Tuberculosis, FA</u>					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>002x</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)		
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		COUNTY STATE
21. I attended the deceased from <u>5-15-58</u> to <u>5-15-59</u> and last saw her/him alive on <u>5-15-59</u> Death occurred at <u>1:05</u> A.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Robert C. Friedman M.D.</u>			22b. ADDRESS <u>Robert Koch Hospital, Koch</u>		22c. DATE SIGNED <u>5-15-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5-20/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>		23d. LOCATION (City, town, or county) <u>MO</u> (State) <u>St. Louis County, Missouri</u>	
24. FUNERAL DIRECTOR <u>Ellis Funeral Home</u> ADDRESS <u>2820 Stoddard St.</u>			25. DATE RECD. BY LOCAL REG. <u>5-19-59</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>

(Licensed Embalmer's Statement on Reverse Side)

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 *Bullton E. Culkin* .....

Licensed Embalmer No. *4198*

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.