

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023209

STATE FILE NUMBER

FILED JUL 13 1959

Registration District No.

Primary Registration District No.

Registrar's No.

6007

S. 300
v. 1-57

92
C

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

MEDICAL CERTIFICATION

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) St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3019 A. Dickson		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 3019 A. Dickson Avenue
3. NAME OF DECEASED (Type or print) Josie Moore		First Middle Last	4. DATE OF DEATH Month Day Year June 22, 1959
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 85
11. BIRTHPLACE (City and state or country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Rosbury		13b. MOTHER'S MAIDEN NAME Jessie Gattrell	14. NAME OF HUSBAND OR WIFE Deceased
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Jessie Gattrell 3019 A. Dickson Avenue
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial weakness & Hypotension. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) 422.2			INTERVAL BETWEEN ONSET AND DEATH 4/27/59 to 6-22-59.
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 4-27-59 to 6-22-59 and last saw her alive on 6-22-59 Death occurred at 11:45 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Dress or title) Robert M. Smith, M.D.		22b. ADDRESS 3007 Easton, etc.	22c. DATE SIGNED 6/23/59.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/26/59	23c. NAME OF CEMETERY OR CREMATORY Washington Park	23d. LOCATION (City, town, or county) (State) Berkley, Missouri
24. FUNERAL DIRECTOR C. B. Foye ADDRESS 1221 North Grand		25. DATE RECD. BY LOCAL REG. JUN 25 '59	26. REGISTRAR'S SIGNATURE Roald Smith, M.D.

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. 755
P. O. 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.