

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031102

FILED VS AUG 26 1959

317

500

2097

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____ STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY St. Louis		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) OR TOWN Koch		Length of stay in 1b 2970 days	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Robert Koch Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4350 Enright Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Oreon Middle _____ Last Moore			4. DATE OF DEATH Month July Day 30 Year 1959		
--	--	--	--	--	--

5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/22/08	9. AGE (last birthday) 51	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
--------------------	-------------------------------	---	---------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Walter	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	---	---	---

13a. FATHER'S NAME Wilbert A. Moore	13b. MOTHER'S MAIDEN NAME Pansy DeBritton	14. NAME OF HUSBAND OR WIFE Monica Mattie Frazier
--	--	--

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. 491-16-9664	17. INFORMANT Address _____
--	--	------------------------------------

18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis - Far Advanced		INTERVAL BETWEEN ONSET AND DEATH 2 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Secondary Amyloidosis	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
--	---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK <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 **June 15, 1959** to **July 30, 1959** and last saw her/him alive on **July 30, 1959**
Death occurred at **11:50 pm** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Edmond P. Lopez, M.D. (Degree or title)	22b. ADDRESS Robert Koch Hospital, Koch, Mo.	22c. DATE SIGNED 7/31/59
---	---	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/5/59	23c. NAME OF CEMETERY OR CREMATORY Saint Peters Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
---	-------------------------	---	--

24. FUNERAL DIRECTOR Charles J. Gates ADDRESS 4107 Finney Ave.	25. DATE RECD. BY LOCAL REG. 8-4-59	26. REGISTRAR'S SIGNATURE John B. M... M.D.
--	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Guylton Swann

Licensed Embalmer No. 4580

P. O. Address 410 79th

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. Swann
If this body is not embalmed, fact should be so stated above.