

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-034126
STATE FILE NUMBER

FILED VS SEP 16 1959

Registration District No. _____ Primary Registration District No. 2 7832 Registrar's No. _____

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Pine Lawn 4151</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DePaul</u>		Length of stay in lb <u>1 1/2 hrs.</u>	d. STREET ADDRESS (If outside, give location) <u>4103 Oakwood Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sandra Kay Moxley</u>			4. DATE OF DEATH Month Day Year <u>8-23-59</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-23-59</u>
9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <u>8</u> Days <u>23</u> IF UNDER 24 HRS.: Hours <u>1 1/2</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ninel</u>	
10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and state or country) <u>St. Louis, MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13a. FATHER'S NAME <u>Gene Moxley</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ruth Norris</u>	14. NAME OF HUSBAND OR WIFE -----
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>none</u>	17. INFORMANT <u>Gene Moxley, Pine Lawn, Mo.</u> Address
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>ANOXIA, SEVERE ATELECTASIS</u> DUE TO (b) <u>PREMATURITY (5 MOS. GESTATION)</u> DUE TO (c) <u>INCOMPETENT CERVIX 762.5</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Premature rupt. of membranes + labor.</u>			INTERVAL BETWEEN ONSET AND DEATH
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 p.m.	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>8-23-59</u> to <u>8-23-59</u> and last saw her alive on <u>8-23-59</u> Death occurred at <u>1:45 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>M.A. Covert, M.D.</u>		22b. ADDRESS <u>100 N. EUCLID</u>	22c. DATE SIGNED <u>8-23-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-24-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Normandy, Mo.</u>
24. FUNERAL DIRECTOR <u>White-Mullen Mortuary, Ferguson</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>AUG 24 59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

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

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 *No Embalming*
L. M. Glute

Licensed Embalmer No. *3973*

P. O. Address. *Terguano, S*

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.