URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-042272
STATE FILE NUMBER

FILED VS NOV 20 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210448

ENDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MISSOURI
Length of stay in 1b: 3 Weeks
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARNES HOSPITAL
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 4326 John Avenue
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First BUFORD Middle Buford H. Last MOORE, JR. Moore
4. DATE OF DEATH: Month NOVEMBER Day 11 Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 9-28-1931
9. AGE (last birthday): 28
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): Retired - Spray Painter
10b. KIND OF BUSINESS OR INDUSTRY: Emerson Elec. Company
11. BIRTHPLACE (City and state or country): Excelsior Springs, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Buford H. Moore, Sr.
13b. MOTHER'S MAIDEN NAME: Emma Fortune
14. NAME OF HUSBAND OR WIFE: Dorothy Moore
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 492-32-8138
17. INFORMANT: Mrs. Dorothy Moore - 4326 John Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	BACTEREMIA	FEW DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	CHRONIC RENAL FAILURE	5 YEARS
DUE TO (c)	CHRONIC GLOMERULONEPHRITIS 592+	10 YEARS

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 MAY 20, 1959, to NOV. 11, 1959 and last saw her/him alive on NOV. 11, 1959
Death occurred at 8:42 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: C. Vannelli, M.D. (Degree or title) M. D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 11/12/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Nov 16, 1959
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Missouri

24. FUNERAL DIRECTOR: Math Hermann & Son, Inc.
ADDRESS: 2161 E. Fair
25. DATE RECD. BY LOCAL REG.: NOV 13 1959
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Wayford G Burnley

Licensed Embalmer No. 4202

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.