

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-021938

FILED VS MAY 31 1960

STATE FILE NUMBER

ENDED

Registration District No. 917 Primary Registration District No. 500 Registrar's No. 1560

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>				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>MEHLVILLE</u>		Length of stay in 1b <u>4 WKS</u>		c. CITY OR TOWN <u>MEHLVILLE</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4111 ELM PARK</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4111 ELM PARK</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>BIRDIE B. MOYERS</u>				4. DATE OF DEATH Month Day Year <u>MAY - 12 - 1960</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</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>MAR-27-1877</u>		9. AGE (last birthday) <u>83</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and state or country) <u>MARION, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
13a. FATHER'S NAME <u>GEORGE KELLEY</u>			13b. MOTHER'S MAIDEN NAME <u>DELIAH LEWIS</u>			14. NAME OF HUSBAND OR WIFE (DECEASED) <u>THEODRICK MOYERS</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>NONE</u>		17. INFORMANT <u>JESSIE MOYERS</u>		Address <u>4111 ELM PARK ST LOUIS 24 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>Concephalopathy</u> DUE TO (b) <u>Multiple cerebral thromboses</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u> <u>2 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic heart disease.</u>						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 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 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 <u>March 15, 1960</u> to <u>May 12, 1960</u> and last saw her alive on <u>May 10, 1960</u> Death occurred at <u>12:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>John T. Lantieri, M.D.</u>				22b. ADDRESS <u>634 N. Grand Blvd.</u>		22c. DATE SIGNED <u>May 13, 1960</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>MAY-14-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RHODES PEARL PEO</u>		23d. LOCATION (City, town, or county) (Date) <u>MARION, MO.</u>			
24. FUNERAL DIRECTOR <u>FEY FUNERAL HOME, MEHLVILLE</u>				25. DATE RECD. BY LOCAL REG. <u>MO 5-13-60</u>		26. REGISTRAR'S SIGNATURE <u>John G. Manning M.D.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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 Gustav W. Sinterle

Licensed Embalmer No. 432

P. O. Address St. Louis 9

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.