

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025348

FILED VS JUN 20 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1694

STATE FILE NUMBER

| | | | | | | | | | | | | |
|---|--|---|---|--|--|---|---|------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Saint Louis | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY ST. CHARLES | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Normandy | | Length of stay in 1b 2 days | | c. CITY OR TOWN Saint Charles | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Normandy Osteopathic Hosp. | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 317 North Fourth St. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Pearl Middle EVE Last Moses | | | | 4. DATE OF DEATH Month May Day 27 Year 1960 | | | | | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 4-16-1884 | 9. AGE (last birthday) 76 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Silex, Missouri | | 12. CITIZEN OF WHAT COUNTRY U S A | | | | | |
| 13a. FATHER'S NAME BAILEY A. CHOATE | | | 13b. MOTHER'S MAIDEN NAME MARGARET ELLEN HUMPHREY | | | 14. NAME OF HUSBAND OR WIFE Clarence Moses | | | | | | |
| 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. NONE | | 17. INFORMANT Address Clarence Moses-317 No. 4th St. ST. CHARLES Mo | | | | | | | | |
| 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) Medullary failure | | | | | | | | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | | | |
| DUE TO (b) Cerebral embolism | | | | | | | 2 hrs. | | | | | |
| DUE TO (c) Generalized arteriosclerosis | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Auricular fibrillation | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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"/> | 20b. SUICIDE <input type="checkbox"/> | 20c. 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 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 Wed-May-18-60 to 5-27-60 and last saw her/him alive on 5-26-60 Death occurred at 3:12 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) J. R. Harrington, D.O. (D.O.) | | | | 22b. ADDRESS St. Charles, Mo 230 A. North Main St. | | | | 22c. DATE SIGNED 5-27-60 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 23b. DATE MAY 28, 1960 | 23c. NAME OF CEMETERY OR CREMATORY OAK GROVE CEM. | | | 23d. LOCATION (City, town, or county) (State) ST. CHARLES, MO | | | | | | |
| 24. FUNERAL DIRECTOR C. L. PRINSTER, ST. CHARLES, MO | | | | 25. DATE RECD. BY LOCAL REG. 5-30-60 | | 26. REGISTRAR'S SIGNATURE John B. Murphy 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 Howard O. Kessler

Licensed Embalmer No. 463

P. O. Address Wentzville

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.