

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 11 1960

60-025416

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1935 STATE FILE NUMBER

INDEXED

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	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Afton</u>		Length of stay in 1b <u>2 weeks</u>	c. CITY OR TOWN <u>St. Louis, 4429 Minnesota</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>Miller Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>DORINDA</u> Middle <u>K.</u> Last <u>MOORE</u>			4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>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>Dec. 5, '64</u>	9. AGE (last birthday) <u>95</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Hamilton County, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Leroy Thomas</u>		13b. MOTHER'S MAIDEN NAME <u>Viann Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>John Moore</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>Mrs. Louis Meyer, 4429 Minnesota Ave.</u>
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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) <u>Cardiac Insufficiency</u>		<u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chronic Arteriosclerosis</u>	<u>6 Mo</u>
	DUE TO (c) <u>Chronic Interstitial Nephritis</u>	<u>6 Mo</u>
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 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"/> 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 8th 1960 to June 23 1960 and last saw ^{her} _{him} alive on June 23 1960
Death occurred at 7:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>N. H. Walters M.D.</u> (Degree or title)	22b. ADDRESS <u>3608 South Grand Blvd.,</u>	22c. DATE SIGNED <u>6/24/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>June 26, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery</u>
23d. LOCATION (City, town, or county) <u>McLeansboro, Illinois.</u>		(State)

24. FUNERAL DIRECTOR <u>Beiderwieden F.H.Inc., 1936 St. Louis Ave.</u>	25. DATE RECD. BY LOCAL REG. <u>6-24-60</u>	26. REGISTRAR'S SIGNATURE <u>John G. Murphy M.D.</u>
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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 _____

Licensed Embalmer No. 45

P. O. Address St. Ia

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.