

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS AUG 8 1960

-60-029086

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 545 Registrar's No. 2175

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Maplewood</u>		Length of stay in 1b <u>1 1/2 Yrs.</u>	c. CITY OR TOWN <u>University City 30</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>Maplewood Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7201 Kingsbury Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MRS. ELIZABETH</u> Middle <u>MOORE</u> Last <u>HUNDLEY</u>	4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1960</u>
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5. SEX <u>f.</u>	6. COLOR OR RACE <u>w.</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>4/29/1868</u>	9. AGE (last birthday) <u>92</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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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>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Clark Co. Kentucky</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>William Boone Moore</u>	13b. MOTHER'S MAIDEN NAME <u>Annie Thomson</u>	14. NAME OF HUSBAND OR WIFE <u>John H. Hundley</u>
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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>Col. Daniel H. Hundley</u> Address <u>7201 Kingsbury 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: IMMEDIATE CAUSE (a) <u>Cerebrovascular thrombosis recurrent 1 week</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>arteriosclerosis</u>	
	DUE TO (c) _____	

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
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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.) _____
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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 _____
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21. I attended the deceased from Jan 1, 1956 to July 20, 1960 and last saw her alive on July 20, 1960
 Death occurred at 3:15 7 a.m. on the date stated above, and to the best of my knowledge from the causes stated.

22a. SIGNATURE (Degree or title) <u>Joseph L. Edwards M.D.</u>	22b. ADDRESS <u>3720 Washington Ave.</u>	22c. DATE SIGNED <u>7/20/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal rail</u>	23b. DATE <u>7/22/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cave Hill Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Louisville, Ky.</u>
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24. FUNERAL DIRECTOR <u>Alexander & Sons 6175 Delmar Blvd.</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>7-21-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Joseph C. Edwards
3720 Washington Ave.
FR. 1 3737

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

Jos. E. McCulloch

Licensed Embalmer No. 296

P. O. Address 6757

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.