RT DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS JAN 13 1961

-60-047768

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12634

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS
Length of stay in 1b: 1 DAY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. JOHNS HOSPITAL
Inside Limits: Yes [X] 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 [X] No [ ]
d. STREET ADDRESS (If outside, give location): 6431 DEVONSHIRE
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: THERESA Middle: M. Last: MOORE
4. DATE OF DEATH: Month: DECEMBER Day: 29 Year: 1960
5. SEX: FEMALE
6. COLOR OR RACE: CAUCASIAN
7. Married [ ] Never Married [ ] Widowed [X] Divorced [ ]
8. DATE OF BIRTH: 3/28/1884
9. AGE (last birthday): 76
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): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (City and state or country): ST. LOUIS, MISSOURI
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: JOSEPH POPE
13b. MOTHER'S MAIDEN NAME: ELIZABETH (LAST UNKNOWN)
14. NAME OF HUSBAND OR WIFE: GARRETT MOORE (DECEASED)
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.: NONE
17. INFORMANT: HELEN MOORE
Address: SEE #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease
INTERVAL BETWEEN ONSET AND DEATH: 3 wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 420.0
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 [X] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [X] 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 Nov 6, 1960, to Dec 29, 1960 and last saw her/him alive on Dec 29, 1960
Death occurred at 4:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John G Matthews MD
22b. ADDRESS: 3707 Watson Rd
22c. DATE SIGNED: 12-30-60

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: 12/31/1960
23c. NAME OF CEMETERY OR CREMATORY: RESURRECTION CEMETERY
23d. LOCATION (City, town, or county) (State): ST. LOUIS COUNTY, MISSOURI

24. FUNERAL DIRECTOR: HOFFMEISTER COLONIAL MORTUARY
ADDRESS: 6464 CHIPPEWA STREET ST. LOUIS MISSOURI
25. DATE RECD. BY LOCAL REG.: DEC 30 1960
26. REGISTRAR'S SIGNATURE: Ford Smith, M.D.

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Bill C Branson

Licensed Embalmer No. 4764

P. O. Address St Louis, M

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