

SOURCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH -61-011291

D APR 7 1961
Registration District No. **318**
Primary Registration District No. **1003**
Registrar's No. **2943**
STATE FILE NUMBER

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.			Length of stay in 1b		c. CITY OR TOWN St. Louis.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Enroute City Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2655 Caroline, Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Robert Middle Randall Last Moore				4. DATE OF DEATH Month March Day 27 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/21/1940	9. AGE (last birthday) 20	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe worker		10b. KIND OF BUSINESS OR INDUSTRY Shoe Factory		11. BIRTHPLACE (City and state or country) Collinwood, Tenn.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Sam Moore			13b. MOTHER'S MAIDEN NAME Ola Dickey			14. NAME OF HUSBAND OR WIFE Nil.	
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. Nil.		17. INFORMANT Address Ola Moore, 2655 Caroline, Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) fractured skull; subdural hemorrhage; suffered when car operated by deceased went out of control and struck abutment in result of careless operating of vehicle by one Percy Ketcherside. DUE TO (b) by Johnson + Scott about 11:00 P.M., March 27, 1961, as a result of careless operating of vehicle by one Percy Ketcherside. DUE TO (c) Chromosomal abnormalities in part of Ketcherside.							INTERVAL BETWEEN ONSET AND DEATH
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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) see above			
20c. TIME OF INJURY Hour 11:00 a.m. / p.m. Month, Day, Year 3-27-61		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street 22			20f. CITY, TOWN, OR LOCATION St Louis, Mo		COUNTY	STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 11:25 A m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Ketchick E Taylor Crown				22b. ADDRESS 1300 Clark		22c. DATE SIGNED 3-28-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-28-61	23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) (State) Lilbourn, Mo.		
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe Inc., 4700 Washington, Blvd.				25. DANIEL B. BOCCARDI		26. REGISTRAR'S SIGNATURE Loal Smith, M.D. S.P.	

MAR 28 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Stanley A. Nixon
Licensed Embalmer No. 4193
P. O. Address S. L.

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.