

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-004244

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1271

AMENDED

FILED FEB 7 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS Mo		c. CITY OR TOWN LEMAY	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION FIRMIN DESLOGE Hosp.		d. STREET ADDRESS (If outside, give location) 2813 MOHATTAN LANE	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last CHARLES MOORE			4. DATE OF DEATH JAN. 28 1962			
---	--	--	-------------------------------	--	--	--

5. SEX MALE	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 AUG. 31 1912	9. AGE (last birthday) 49	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) PIPE FITTER.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ST. LOUIS Mo	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	-----------------------------------	---	------------------------------------

13a. FATHER'S NAME PERRY EDWARD MOORE	13b. MOTHER'S MAIDEN NAME CARRIE CRAWSHAW	14. NAME OF HUSBAND OR WIFE AGNES MOORE
---------------------------------------	---	---

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.	17. INFORMANT AGNES MOORE 2813 MOHATTAN LANE
---	-------------------------	--

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) Aortic & Mitral Stenosis		16 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic rheumatic valvulitis		38 yrs
DUE TO (c) mitral 4/10x		

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 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 1/27/62 to 1/28/62 and last saw him alive on 1/21/62	
Death occurred at 7 p m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE Maud Allen MD	22b. ADDRESS 3120 Washington Ave	22c. DATE SIGNED 1/29/62
------------------------------	----------------------------------	--------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE FEB. 1 1962	23c. NAME OF CEMETERY OR CREMATORY NEW ST. MARCUS	23d. LOCATION (City, town, or county) ST. LOUIS Mo
--	-----------------------	---	--

24. REGISTRAR'S SIGNATURE Thomas Letic 2906 Gravois	25. DATE RECD. BY LOCAL REG. JAN 29 1962	26. REGISTRAR'S SIGNATURE Earl Smith. M.D.
---	--	--

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

QC 3-6525
130-430
RM 901

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 Eleanor Province

Licensed Embalmer No. 3403

P. O. Address 2906 Province

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.