

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-037860

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9600 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

Being born at St. Louis Maternity and transferred
 BY AFFIDAVIT OF CHILDREN HOSPITAL DOCUMENT

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>12 hrs 30 min</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis 26</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>St. Louis Children's Hospital</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>9519 Caravan</u>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Roy Moon III</u>						4. DATE OF DEATH Month Day Year <u>September 12, 1963</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-9-63</u>		9. AGE (last birthday) Months <u>3</u> Days <u>3</u> Hours <u></u> Min. <u></u>		IF UNDER 1 YEAR IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>United States</u>			
13a. FATHER'S NAME <u>Thomas Roy Moon, Jr.</u>				13b. MOTHER'S MAIDEN NAME <u>Jeanne Scholtey</u>				14. NAME OF HUSBAND OR WIFE <u>Single</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></u>		17. INFORMANT Address <u>Mildred E. Bowie - 500 S. Kingshighway</u>					
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>Bacterial meningitis</u>										INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>340.3</u>											
DUE TO (c) <u></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 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. <u></u>		Month, Day, Year <u></u>		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 <u>9-11-63</u> to <u>9-12-63</u> and last saw him alive on <u>9-12-63</u> Death occurred at <u>8:53 AM, 9/12/63</u> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>Harold Parkowsky, M.D.</u>						22b. ADDRESS <u>500 So Kingshighway</u>			22c. DATE SIGNED <u>9-17-63</u>		
23b. BURIAL, CREMATION, REMOVAL (Specify)		23c. DATE <u>9-30-63</u>		23d. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>		23e. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>					
24. FUNERAL DIRECTOR ADDRESS <u>MO. ANATOMICAL BOARD, 1402 S. GRAND</u>						25. DATE RECD. BY LOCAL REG. <u>SEP 26 1963</u>		25. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>			

USE BLACK INK OR TYPEWRITER RIBBON

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.