

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER **63-046501**

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 3344

FILED NOV 20 1963

VS 300
Rev. 4/59

14021

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Des Peres		Length of stay in lb	c. CITY OR TOWN Chesterfield
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chastain's Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3 Chesterton Lane
3. NAME OF DECEASED (Type or print) First Grace Middle B. Last Moon		4. DATE OF DEATH Month October Day 31 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/4/1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY Cleaning Establishment	9. AGE (last birthday) 76
11. BIRTHPLACE (City and state or country) Jasper Co., Mo.		12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Samuel Bowers		13b. MOTHER'S MAIDEN NAME Rebecca Cairns	14. NAME OF HUSBAND OR WIFE Alfred C. Moon
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 Gentry Philpott, 3 Chesterton Lane
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 week 5 years 6 yrs
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 checked="" 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 May 22 1962 to 10/31/63 and last saw him alive on 70/30/63 Death occurred at 3:25 pm on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) J. W. Henderson MD		22b. ADDRESS 1 Clarkton Rd Chesterfield Mo	22c. DATE SIGNED 10/2/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 11-1-63	23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. 11-1-63	26. REGISTRAR'S SIGNATURE John B. Mumfley MD

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 _____
Not Embalmed
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.