

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

22763

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

File No. ....

Township.....

Registration District No. **1003**

Registered No. **6172**

City **St. Louis**

(No. **Benards City Hosp** St. .... Ward)

**2. FULL NAME** Mary Mosley

(a) Residence. No. 1821 So. 2nd St., 23 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <b>Female</b>	4. COLOR OR RACE <b>Colored</b>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <b>Married</b>
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5A. IF MARRIED, WIDOWED, OR DIVORCED  
HUSBAND OF (OR) WIFE OF **Henry Mosley**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 16 1884

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
<b>45</b>			<b>28</b>	

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work **Domestic**  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) **Missouri**  
(STATE OR COUNTRY)

**PARENTS**

10. NAME OF FATHER	<b>Unknown</b>
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)	<b>Unknown</b>
12. MAIDEN NAME OF MOTHER	<b>Mary Rollan</b>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)	<b>Missouri</b>

14. INFORMANT **-Henry R. Mosley**  
(Address) **1821 So. 2nd**

15. FILED **1929** **May C. Stanley** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 4 1929

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at 3:30 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cerebral apoplexy  
(None-traumatic)  
82 A (duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) 74 A (duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRAICTED 74 A  
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? eyes

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) J. W. Ferris  
6/5 1929 (Address) Dr. Corone

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Washington Park DATE OF BURIAL June 7 1929

20. UNDERTAKER Western Mutual ADDRESS 2702

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

K. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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