

**BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

9192

1. PLACE OF DEATH
 County Clay Registration District No. 198
 Township Fishing-River Primary Registration District No. 3041
 City Excelsior Springs, Mo. U. S. Veterans Hospital
 St. _____ Ward _____

2. FULL NAME MOSLEY, Robert
 (a) Residence. No. U. S. Veterans Hospital St. _____ Ward East St. Louis, Illinois
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 0 yrs. 0 mos. 7 ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

File No. _____
 Registered No. 12-1
 St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>colored</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>single</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>single</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Feb. 26, 1891</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>40</u>	<u>0</u>	<u>7</u>	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>unknown</u> (c) Name of employer _____				
9. BIRTHPLACE (CITY OR TOWN) <u>Arkansas</u> (STATE OR COUNTRY)				
PARENTS	10. NAME OF FATHER <u>Tom Mosley</u>			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>unknown</u> (STATE OR COUNTRY)			
	12. MAIDEN NAME OF MOTHER <u>unknown</u>			
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>unknown</u> (STATE OR COUNTRY)			

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 5, 1931 19
 17. I HEREBY CERTIFY, That I attended deceased from 2-26-31, 19____ to 3-5-31, 19____, that I last saw him alive on 3-5-31, 19____, and that death occurred, on the date stated above, at 1:20 p.m. m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chr. Pulmonary Tuberculosis advanced
unknown (duration) ? yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) none (duration) _____ yrs. _____ mos. _____ ds.
 18. WHERE WAS DISEASE CONTRACTED? unknown
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF none
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? none
 (Signed) Samuel Johnson M. D.
3-5-31 (Address) U.S. Veterans Hospital Excelsior Springs, Mo.
 *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 National Cemetery Leavenworth, Kansas. DATE OF BURIAL 3-10-31 19____
 20. UNDERTAKER Hersent Hope ADDRESS Excelsior Springs

N. 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.

APR 21 1931

14. INFORMANT Hospital Records
 (Address) USVH Excelsior Springs, Mo.
 15. FILED 3/5 31 Y. D. Draven REGISTRAR

