

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

Do not use this space.

26490

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township.....**St. Louis** Primary Registration District No. **1003**
 City.....**St. Louis** (No. **4333**) W. Belle

File No.
 Registered No. **7642**
 St. Ward

2. FULL NAME

(Per) **Samuel A. Moseley**
 (a) Residence. No. **4333 W. Belle** St., **11** Ward.
 (Usual place of abode) (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 Male	4. COLOR OR RACE Negro	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ophelia Moseley		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 7 1862		
7. AGE	YEARS 68	MONTHS 6
	DAY 25	IF LESS than 1 day,hrs. ormin.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer)..... (c) Name of employer..... Minister		
9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY) Lebanon		
PARENTS	10. NAME OF FATHER Price C Moseley	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY) Don't know	
	12. MAIDEN NAME OF MOTHER Harriet Childers	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY) Don't know	
14. INFORMANT..... (Address) 4333 W. Belle		
15. FILED..... REGISTRAR		

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **July 2 1931**
 17. I HEREBY CERTIFY, That I attended deceased from **June 24**, 1931, to **July 2**, 1931, that I last saw him alive on **July 1**, 1931, and that death occurred, on the date stated above, at **2 P.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis acute
92 AD
93 A
97 (duration) yrs. mos. **9** ds.
 CONTRIBUTORY (SECONDARY) **Mitral regurgitation & Arteriosclerosis** (duration) **2** yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH. DATE OF.....
 WAS THERE AN AUTOPSY?
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) **W. H. Starnes**, M. D.
 , 19 (Address) **822 W. Jefferson Ave**

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL
St. Peters
 2. UNDERTAKER
W. Russell and Co.
 DATE OF BURIAL
7/8 1931
 ADDRESS **2732**

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

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.

