

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.

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

Do not use this space.

SEP 16 1935

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St Louis Mo.** (No. **1839 a Biddle St.**)

File No. **27905**

Registered No. **6959**

St. Ward)

2. FULL NAME **Susie Mosbey**

(a) Residence, No. **1839 a Biddle St.** St. **21** 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 **Female** 4. COLOR OR RACE **Colored** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Clarence Mosbey**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **May 17th, 1916**

7. AGE YEARS **19** MONTHS **2** DAYS **27** If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **Housewife**
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ark.**

FATHER MOTHER

13. NAME **Oscar Nunn**
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Jackson County Co Ark.**
15. MAIDEN NAME **Mattie Parrott**
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Jackson Co, Ark.**

17. INFORMANT **Clarence Mosbey** (ADDRESS) **1839 a Biddle St.**
18. BURIAL, CREMATION, OR REMOVAL PLACE **Father Dixon** DATE **8/17/35** 1935

19. UNDERTAKER **Ellie Funeral Home** (ADDRESS) **2820 Stoddard St.**

20. FILED **AUG 16 1935** **J. Bredeck** Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **8-13-35** 19**35**

22. I HEREBY CERTIFY, That I attended deceased from **July 5**, 19**35**, to **Aug 13**, 19**35**

I last saw him alive on **Aug 12**, 19**35**. Death is said to have occurred on the date stated above, at **7/25** P. M.
The principal cause of death and related causes of importance were as follows:

Acute Pneumonia
Phthisis
Acute Pneumonia phthisis

Other contributory causes of importance:

Name of **Laboratory** State of **Mo**
What test confirmed diagnosis? **Clinical** Was there an autopsy? **NO**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) **J. M. Williams**, M. D.

(Address) **823. 71 St**

O. sic # 410

