

0.  
2-43  
7-30  
X31

State File No. \_\_\_\_\_

Registration District No. 42

Primary Registration District No. 1805

Registrar's No. 696

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Joseph Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 week  
(Specify whether  
In this community 63 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2010 Savannah, Avenue  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13th.  
year 1943 hour 9:55 minute A. M.  
21. I hereby certify that I attended the deceased from April  
27, 1943, to June 13, 1943,  
that I last saw him alive on June 13, 1943,  
and that death occurred on the date and hour stated above.

Immediate cause of death Brain Tumor Rt. Lateral Ventricle shor  
Duration

Due to   
Due to   
Other conditions   
(include pregnancy within 3 months of death)

Major findings:   
Of operations   
Of autopsy State above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)   
(b) Date of occurrence   
(c) Where did injury occur?   
(City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work?  (Specify type of place) \_\_\_\_\_  
(e) Means of injury   
23. Signature Gustav Flou (M. D. or other) M.D.  
Address Rocky Point Bldg St Joseph, Mo. Date signed 6/14/43

3. (a) PRINT FULL NAME Frank Paul Moskau Jr.

3. (b) If veteran, name war No 3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Lorean M. Moskau 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased May 18 1877  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
66 0 25 hr. min.

9. Birthplace Doniphan County Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation City Employee

11. Industry or business Board of Public Works

12. Name Frank P. Moskau

13. Birthplace Berlin Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Ruth Jane Cook

15. Birthplace St. Joseph Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Lorean M. Moskau

(b) Address 2010 Savannah Ave., St. Joseph, Mo.

17. (a) Burial (b) Date thereof 6 - 15 - 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Walter Meierhoffer

(b) Address 13th. & Faron St., St. Joseph, Mo.

19. (a) 6-15-43 (b) Rose Heigoy  
(Date received local registrar) (Registrar's signature)

WRITE LEAVENDI - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

*Dr. Law.*

**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 \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed *Geo E Daniel*

Licensed Embalmer No. 3300 Missouri

P. O. Address St. Joseph, Mo.

**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 this body is not embalmed, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. July  
Registrar's No. 696

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Frank Paul Moskan Jr  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M. 3  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.  
Immediate cause of death Brain tumor of lateral ventricle papillary Adenocarcinoma of choroid Plexus Right lateral Ventricle, Melanotic. Duration short

4. Sex m 5. Color or race w  
6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: may 1918 (Month) (Day) (Year)  
8. AGE: Years 66 Months 0 Days 0 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Kan (City, town, or county) (State or foreign country)  
10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) (Specify type of place)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations 552  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—U.S. RECOMMENDING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

20886