

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

6595

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town Saint Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Park Lane Memorial Hospital.
(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 Missouri. (b) County _____
(c) City or town Saint Louis,
(If outside city or town limits, write "RURAL")
(d) Street No. 3615 Marceline Terrace.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Fred Charles Mosier

3. (b) If veteran, name war _____ 3. (c) Social Security No. 492-10-7740

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Married.

6. (b) Name of husband or wife Natalia Mosier 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased March 27th, 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 3 21 hr. min.

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

10. Usual occupation Moving Picture Operator

11. Industry or business

12. Name John Mosier

13. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Natalia Mosier

(b) Address 3615 Marceline Terrace.

17. (a) Burial (b) Date thereof July 21, 1943.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Lawn Cemetery

18. (a) Signature of funeral director Ziegenheim Bros.

(b) Address 8409 Gravois Ave.

19. (a) Jul 21 1943 (b) J. F. [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18th,
year 1943. hour 9 minute 0 A. M.

21. I hereby certify that I attended the deceased from 6-28-43, 19 , to 7-18-43, 19 ;
that I last saw him alive on 7-18-43, 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to [Signature]

Due to [Signature]

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration

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 [Signature] (M.D. or other) M.D.

Address 4930 Lindell Date signed 7/19/43

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

MOTHER FATHER

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..... *Juddie A. Ziegenhein*

Licensed Embalmer No. *2270*

P. O. Address *6409 Bearoid Ave*

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.