

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8334
Registrar's No. 455

Registration District No. 217 Primary Registration District No. 3069

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 50 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17
(d) Street No. 4491 West Pine Blvd (If rural, give location) 9
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country /

3. (a) PRINT FULL NAME Elizabeth L. Moser

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Leo Moser 6. (c) Age of husband or wife if alive 5 years 1867

7. Birth date of deceased: December 5 1867
(Month) (Day) (Year)

8. AGE: Years 76 Months 2 Days 15 If less than one day hr. min.

9. Birthplace Staten Island N. Y. /
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business
12. Name Patrick Murphy
13. Birthplace unknown Ireland /
(City, town, or county) (State or foreign country)

14. Maiden name Lillian Edgar
(City, town, or county) (State or foreign country)

15. Birthplace unknown Ireland /
(City, town, or county) (State or foreign country)

16. (a) Informant J. Edgar Moser
(b) Address City of Ladue

17. (a) Burial (b) Date thereof 2 22 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary
18. (a) Signature of funeral director Wagoner Mortuary
(b) Address 4161 Lindell Blvd
19. (a) FEB 24 1944 (b) E. G. Moser, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 20
year 1944 hour 4 minute 5A.M.
21. I hereby certify that I attended the deceased from Feb 15 1944 to Feb 20 1944
that I last saw her alive on Feb 19 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 1 week
Due to Arterio-Sclerotic Heart Disease 5 yrs

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

Major findings: Of operations 93d
Of autopsy _____
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) _____
(a) _____ (b) _____
23. Signature Ra Kusella (M. D. or other) 2/21/44
Address 37 20 Washington Date signed 2/21/44

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

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8
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Dr. Ralph C. Russell
3720 Washington

MAR 9 1944

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

Neville E. Schwitter

Licensed Embalmer No.

3696

P. O. Address

4161 Seidell Blvd

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.