S. No. 2
M—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 3 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11587

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 3714

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: De Paul Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3447 Halliday Ave.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Joseph Theodore Mosar

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Florence M.

6. (c) Age of husband or wife if alive years

7. Birth date of deceased March (Month) 25 (Day) 1890 (Year)

8. AGE: Years 55 Months 1 Days 2 If less than one day hr. min.

9. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business City of St. Louis

FATHER
12. Name Charles Mosar
13. Birthplace Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Irene (Unknown)
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Florence M. Mosar
(b) Address 3447 Halliday

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 4 28 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Sullivan Funeral Dir
(b) Address 2849 No. Euclid, Ave.

19. (a) APR 26 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 25th day year 1945 hour 4:10 minute A M.

21. I hereby certify that I attended the deceased from 2nd January, 1945, to 25th April, 1945 and that I last saw him alive on April 24th, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma head of Pancreas — Duration 4 mos

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Carcinoma head of pancreas

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) no

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. F. Gallagher (M. D. or other) MD

Address 3903 Olive Date signed 4/25/45

(Licensed Embalmer's Statement on Reverse Side)

Dr. J. F. Gallagher

3903 Olive St. Je. 56000

Pa - 53 - 1

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 Robert L. Brinkman

Licensed Embalmer No. 3553

P. O. Address.....

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.