

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED JAN 28 1946
Registration District No. _____

Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution:
3524a. Market St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 years
In this community 10 years
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Gussie Mosby
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Col. 6. (a) Single, widowed, married, divorced, widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept., 26 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
55 3 9 hr. min.

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

10. Usual occupation Domestic

11. Industry or business _____
MOTHER FATHER { 12. Name John Brown
13. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)
14. Maiden name May Brown
15. Birthplace Jerseyville Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address 3524a. Market St.

17. (a) Removal (b) Date thereof 1-10-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Jerseyville, Ill.

18. (a) Signature of funeral director Ellis Fun., Home
(b) Address 2820 Stoddard St.

19. (a) _____ (b) J. F. Bruck
(Date received local registrar) (Registrar's signature)

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. 3524a. Market St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan., day 4
year 1946 hour 10:40 minute _____ P. M.
21. I hereby certify that I attended the deceased from 4-25
1945 to 1-4 1946
that I last saw him alive on 1-4 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Mitral insufficiency
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
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)
(e) Means of injury _____
23. Signature J. W. W. Williams (M. D. or other)
Address 3360 a Franklin Cir Date signed 1-5-46

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

JAN 8 1946

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 William G. Cullin.....

Licensed Embalmer No. 4198.....

P. O. Address 7912 Laurentian St. Harris, B. N.

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.