

FILED MAY 17 1946
Registration District No. **318**

Primary Registration District No. **1002**

Registrar's No. **4125**

1. PLACE OF DEATH

(a) County **ST. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **Homer G. Phillips Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days**
(Specify whether years, months or days) **30 yrs**

3. (a) PRINT FULL NAME **Bessie Moss**

3. (b) If veteran, name was **No** 3. (c) Social Security No. **No**

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **divorced**
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive **18 yrs**

7. Birth date of deceased **Oct.** (Month) **2** (Day) **1898** (Year)

8. AGE: Years **47** Months **6** Days **4** If less than one day hr. min.

9. Birthplace **Mississippi** (City, town, or county) (State or foreign country)

10. Usual occupation **House Work**

11. Industry or business

12. Name **UNKNOWN**

13. Birthplace **"** (City, town, or county) (State or foreign country)

14. Maiden name **"** (City, town, or county) (State or foreign country)

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

16. (a) Informant **Walter Dixon**

(b) Address **2810 Washington**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **5-12-46** (Month) (Day) (Year)

(c) Place: burial or cremation **Greenwood**

18. (a) Signature of funeral director **Greenwood**

(b) Address **3103 Washington**

19. (a) **MAY 8 1946** (Date received local registrar) (b) **J. F. Bradeck** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **ST. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4250 Evans Ave**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **6**
year **1946** hour **3** minute **10 P.** M.

21. I hereby certify that I attended the deceased from **5-4** 19**46** to **5-6** 19**46**
that I last saw her alive on **May 6** 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Stomach**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **No**

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 **A. G. Griffin** (M. D. or other)

Address **2601 N. Whittier** Date signed **5/7/46**

Duration

Unk

PHYSICIAN

Underline the cause to which death should be charged statistically.

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. 179,500
working under my personal supervision.

Signed H. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.