No. 2
-1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36683

FILED OCT 29 1947

Registration District No. 3477 Primary Registration District No. 6076 Registrar's No. 2207

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch (rural) (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Robert Koch Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 82 days (Specify whether years, months or days)
In this community 48 years

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. 4254a Fairfax (If rural, give location) 9
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME Moss, George
3. (b) If veteran, name war
3. (c) Social Security No. None
4. Sex Male 2
5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ada Bell Moss
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July (Month) 17 (Day) 1896 (Year)

8. AGE: Years	Months	Days	If less than one day
51	2	28	hr. min.

9. Birthplace New Orleans (City, town, or county) Louisiana (State or foreign country) 1
10. Usual occupation Pool Room Operator
11. Industry or business
FATHER 12. Name Frank Moss ?
13. Birthplace ?? (City, town, or county) (State or foreign country) 1
MOTHER 14. Maiden name Callie ??
15. Birthplace ?? (City, town, or county) (State or foreign country) 1
16. (a) Informant Hospital Records
(b) Address Robert Koch Hospital
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/47 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park Cem.
18. (a) Signature of funeral director Ellis Funeral Home
(b) Address 2820 Stoddard St.
19. (a) 10-20-47 (Date received local registrar) (b) Cecil B. Sharp M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 15 year 1947 hour 4 minute 30 P. M.
21. I hereby certify that I attended the deceased from 7-25- 1947 to 10-15 1947 that I last saw him alive on 10-15 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	9 mo. (??)
Due to 13	
Due to	(??)
Other conditions Diabetes Mellitus (Include pregnancy within 3 months of death)	10 yrs.

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury 0
23. Signature William C. Barton, II (M. D. or other)
Address Robert Koch Hospital Date signed 10-16-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 Fulton E. Culkin

Licensed Embalmer No. 4198

P. O. Address St Louis 13 Mo

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.