

No. 300
-10-47
-17-39
I 3906

#90319

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38469**
9854
Registrar's No. _____

Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

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

(c) Name of hospital or institution: St. Louis City Hospital—Max C. Starkloff
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0 (Specify whether
years, months or days)

3. (a) PRINT FULL NAME RANDELL MOSER

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced S. D.

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Jan. 31 1948
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>9</u>	<u>12</u>		hr. _____ min.

9. Birthplace Richmond Heights, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business

12. Name Simon O. Moser

13. Birthplace Overland, Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Rosemary Clark

15. Birthplace Clay, Ky.
(City, town, or county) (State or foreign country)

16. (a) Informant Rosemary Moser

(b) Address 9409 Edmond Overland 21 Mo

17. (a) Burial (b) Date thereof 11/15/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles Cem

18. (a) Signature of funeral director Baumann Bros & Co

(b) Address 2501 Woodson Rd. Overland 11 Mo

19. (a) NOV 13 1948 J. B. Lassater
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Overland
(If outside city or town limits, write "RURAL")

(d) Street No. 9409 Edmond Drive
Memorial (If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 12th
year 1948 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from 9/29/48
_____ 19 _____ to Nov. 12th 19 48
that I last saw him alive on Nov. 12th and that death occurred on the date and hour stated above.

Immediate cause of death tuberculosis meningitis Duration 6 wks.

Due to _____

Due to _____

Other conditions pulmonary tuberculosis
(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? _____

23. Signature Frank J. [Signature]
While at work? _____ (Specify type of business)

23. Signature 1515 Lafayette 11/12/48 D. or other) _____
Address _____ Date signed _____

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 Oscar F. Mueller

Licensed Embalmer No. 3039

P. O. Address Cleveland 18 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.