

FILED JUL 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20045

State File No.

BIRTH NO. _____ REG. DIST. NO. 160 PRIMARY REG. DIST. NO. 5392 Registrar's No. 21

1. PLACE OF DEATH a. COUNTY <u>Jefferson</u> <u>Jefferson</u> b. CITY (If outside corporate limits, write RURAL and give town OR TOWN <u>Near Crystal City</u>) c. LENGTH OF STAY (In this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1</u>		2. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> d. STREET ADDRESS (If rural, give location) <u>4357A Maryland Ave.</u>	
---	--	---	--

3. NAME OF DECEASED (Type or Print) a. (First) <u>Golden</u> b. (Middle) <u>Everett</u> c. (Last) <u>Mosier</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 14 1949</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	
8. DATE OF BIRTH <u>April 26, 1916</u>		9. AGE (In years last birthday) <u>33</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>18</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fountain Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Katz Drug Store</u>		11. BIRTHPLACE (State or foreign country) <u>San Francisco, Cal.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

13a. FATHER'S NAME <u>Charles Mosier</u>		13b. MOTHER'S MAIDEN NAME <u>Amanda K. Williams</u>		14. NAME OF HUSBAND OR WIFE <u>Evelyn Mosier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Amanda K. Mosier</u> ADDRESS <u>St. Louis, Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>(Verdict of Jury) Committed suicide 14 May 1949 when he leaped from Coak's bridge in St. Louis into the Mississippi River</u>		MEDICAL CERTIFICATION	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <u>87 1/2</u>	

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>suicide</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Louis</u> <u>MO</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from INQUEST, 19 MAY 19 49, that I last saw the deceased alive on _____, 19 _____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE <u>Harold J. Mohr</u> (Degree or title) <u>3 Corner 11th & 20th Sts. MO</u>		23b. ADDRESS _____		23c. DATE SIGNED <u>May 17 1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>May 21, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Opentry R. Polite</u> ADDRESS <u>Crystal City, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>May 20, 1949</u>		REGISTRAR'S SIGNATURE <u>Oliver Bellville</u> <u>142</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Opentry R. Polite</u> ADDRESS <u>Crystal City, Mo.</u>	

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JUN 24 1949

JUL 1 1949

RECEIVED
JUL 1 1949

FED 1 8 1949

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 _____

working under my personal supervision. _____ Student Embalmer No. _____

Signed _____
Student Embalmer

Signed *Geoffrey R. Polite*

Licensed Embalmer No. 3481

P. O. Address *Crystal City, Va*

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.

JUL 6 1949