

FILED AUG 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25135

State File No.

#92232

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 6695

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 10- 4039 Kossuth Ave.	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) LAURA	b. (Middle) B	MOSGROVE August 1st, 1949	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow	8. DATE OF BIRTH January 8, 1874
9. AGE (In years last birthday) 75		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Farmington, Missouri.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME William Young		13b. MOTHER'S MAIDEN NAME Mary Doss	
14. NAME OF HUSBAND OR WIFE Roy Mosgrove		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Mrs. Julia Edens 4039 Kossuth Ave.	
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, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho pneumonia (b) Cerebral Edema 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. Atherosclerotic Heart Disease	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 930			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? H200			
22. I hereby certify that I attended the deceased from 7/5/49, 19, to 8/1/49, 19, that I last saw the deceased alive on 8/1/49, 19, and that death occurred at 2:40am, from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Charon Hendrix, M.D.		23b. ADDRESS U 1515 Lafayette Ave.,	
23c. DATE SIGNED 8/1/49			
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 8-4-49	
24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri.	
DATE REC'D BY LOCAL REG. AUG 2 1949		REGISTRAR'S SIGNATURE J. B. Sosa	
25. FUNERAL DIRECTOR'S SIGNATURE Math Hermann & Son, Inc. 2161 E. Fair Ave.		ADDRESS	

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Harner V. Dritz

Licensed Embalmer No. _____

3882

P. O. Address _____

St. Louis, 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.