

FILED OCT 13 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32037

State File No. 8434

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>5 days</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Webster Groves, 19</b>		96 7 4		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>N.W. - 209 Clara Ave.</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>Willis Everett Mosier</b>			b. (Middle) _____		c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) <b>Sept 28 1949.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>July 12 1876</b>		9. AGE (in years last birthday) <b>73</b>	10. IF UNDER 1 YEAR Months <b>2</b> Days <b>16</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrical Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Union Electric</b>		11. BIRTHPLACE (State or foreign country) <b>Washington Co. Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>James Mosier</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Statia Mosier</b>		14. NAME OF HUSBAND OR WIFE <b>Ida Mae Mosier (Brewer)</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>493-05-3101</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Wm. Wood, 209 Clara Ave., W.G. Mo.</b>				
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.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <b>5 Mo.</b>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Malignant metastases to liver</b>				ANTECEDENT CAUSES <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b>				DUE TO (b) <b>from unknown source</b>
				DUE TO (c) <b>Probably from lung</b>				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								
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)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>HTW. MO. MO.</b>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>162X</b>				
22. I hereby certify that I attended the deceased from <b>Aug 31, 1949</b> to <b>Sept 28, 1949</b> that I last saw the deceased alive on <b>Sept 28, 1949</b> , and that death occurred at <b>11:00 a.m.</b> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <b>Edw. J. Finkbeiner M.D.</b>				23b. ADDRESS <b>19 E. Laclede Ave. Webster Groves Mo.</b>		23c. DATE SIGNED <b>9/28/49</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		24b. DATE <b>9-30-'49.</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Louis</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>			
DATE REC'D BY LOCAL REG. <b>SEP 30 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Fusater</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>MITTELBERG FUN. HOME</b>		ADDRESS <b>WEBSTER GROVES 19 MO</b>		

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 *Albert G. Noppe* .....

Licensed Embalmer No. *2971* .....

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.