

FILED FEB 23 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6467
1309

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1000** Registrar's No. _____

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		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 1436 N 14th St	
3. NAME OF DECEASED (Type or Print) a. (First) Otis b. (Middle) c. (Last) Mozell			4. DATE OF DEATH (Month) (Day) (Year) Feb. 3 1951
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Unknown - abt 4-4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Unknown
12. CITIZEN OF WHAT COUNTRY? U S A ?		13. FATHER'S NAME Unknown	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Elizabeth Rhodes, 2601 N Whittier St	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Elizabeth Rhodes, 2601 N Whittier St			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Space Occupying Lesion			INTERVAL BETWEEN ONSET AND DEATH Undet.
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			
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)	
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? 23 7X	
22. I hereby certify that I attended the deceased from 1-27- 19 51 , to 2-3 19 51 , that I last saw the deceased alive on 2-3 19 51 , and that death occurred at 6 a m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Herbert J. Curwin, M.D.		23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 2-5-51
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE FEB 9 1951	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. FEB 9 1951	REGISTRAR'S SIGNATURE J B Forster	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service Inc.	

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.....

Licensed Embalmer No.....

P. O. Address.....

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.