

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH 541

30260

State File No. _____

DEAD AUG 15 1952

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547 Registrar's No. 2044

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) <u>Clayton - No. 1</u>		c. LENGTH OF STAY (in this place) <u>3 yrs</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> <u>2269</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>			d. STREET ADDRESS (If rural, give location) <u>3504 N. 14th</u>		

3. NAME OF DECEASED (Type or Print) a. (First) <u>Elizabeth</u> b. (Middle) _____ c. (Last) <u>Mossinghoff</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>7 29 1952</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>2-23-1862</u>		9. AGE (In years last birthday) Months Days <u>90</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Germany</u> <u>4</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>

13a. FATHER'S NAME <u>Theodore Koch</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Al Mossinghoff - 5089 Rookin</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Senescent frailty, arteriosclerosis</u> 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. <u>4500</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2</u>
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19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>None</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) <u>None</u>		21e. INJURY OCCURRED WHILE AT WORK? (Specify) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	21f. HOW DID INJURY OCCUR? <u>None</u>		

22. I hereby certify that I attended the deceased from 7/27, 1952, to 7/29, 1952, that I last saw the deceased alive on 7/28, 1952, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Robert E. Fox M.D. D.P.</u>		23b. ADDRESS <u>634 N. Grand Blvd.</u>		23c. DATE SIGNED <u>7/30/52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug 1, 1952</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>		

DATE REC'D BY LOCAL REG. <u>7-31-52</u>	REGISTRAR'S SIGNATURE <u>Herbert P. Donnell</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Edward Koch + Son - 3516 E. 14th</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48
002
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STATEMENT BY LICENSED EMBALMER

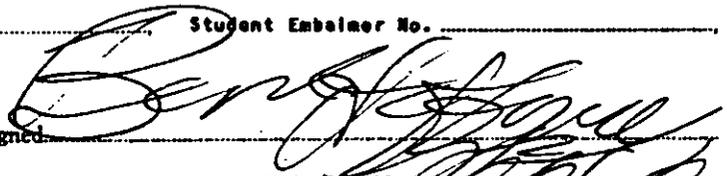
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

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.