

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40927

REC'D DEC 4-1953 93178

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11134**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY 2219		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 5 hrs.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 0		
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hosp.			d. STREET ADDRESS (If rural, give location) 21 3139 Sheridan		

3. NAME OF DECEASED (Type or Print) a. (First) Mosley b. (Middle) Mosley c. (Last) Mosley			4. DATE OF DEATH (Month) (Day) (Year) 11 15 53		
5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 11-15-53		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? 0

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME Lula Bell Mosley	14. NAME OF HUSBAND OR WIFE
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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 Arthur M. Howard, R.R. 2601 N. Whittier		ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Prematurity			
*This does not mean the mode of dying, such as heart failure, asphyxia, 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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 776X

22. I hereby certify that I attended the deceased from **11-15, 1953**, to **11-15, 1953**, that I last saw the deceased alive on **11-15, 1953** and that death occurred at **2:45 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) William H. Sintelov, M.D.	23b. ADDRESS 2601 N. Whittier Street	23c. DATE SIGNED 11-18-53
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 11-30-53	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. NOV 24 1953	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	FUNERAL DIRECTOR'S SIGNATURE Rowland-Aker Mortuary Service	ADDRESS 4164 V. Director Ave. St. Louis 10, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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 complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.