

FILED SEP 2 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29113 AN

Registrar's No. 7318

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|---|--|--|---|--|--|---|--|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1002 | | Registrar's No. 7318 | | | |
| 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. LENGTH OF STAY (In this place) _____ | | c. CITY OR TOWN St. Louis | | d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer Phillips Hospital | | | e. STREET ADDRESS (If rural, give location) 2721a Hickory 2229 | | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Sally | | | b. (Middle) Elzora | | c. (Last) Mosby | | 4. DATE OF DEATH (Month) (Day) (Year) 8 - 6 - 54 | | |
| 5. SEX Female 2 | | 6. COLOR OR RACE Negro | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant | | 8. DATE OF BIRTH Oct. 13, 1952 | | 9. AGE (In years less birthday) Months Days Hours Mts. I 1 1 | |
| 10a. USUAL OCCUPATION (Give kind of work done throughout of working life, even if retired) Nil | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (City and State or Foreign Country) Memphis, Tenn | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13a. FATHER'S NAME Sampson Mosby | | | 13b. MOTHER'S MAIDEN NAME Bertha Collier | | | 14. NAME OF HUSBAND OR WIFE _____ | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Bertha Collier 2721a Hickory | | | | | |
| 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sub-dural Hemorrhage (traumatic) suffered in fall from porch to ground below at home at 2721a Hickory, about 1:15 pm. Aug 2 1954 | | | | | | INTERVAL BETWEEN ONSET AND DEATH _____ | |
| | | ANTECEDENT CAUSES | | DUE TO (b) Marital conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | | | |
| | | 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 Accident | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT (Specify) Suicide | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) St. Louis Mo | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug 2 54 1:15 pm | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? ODD E9020 | | | | | |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:30 P.M., from the causes and on the date stated above. 21 | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) Patrick Taylor Carraway | | | | 23b. ADDRESS 1300 East | | | 23c. DATE SIGNED 8.7.54 | | |
| 24a. BURIAL, CREMATION, REMOVAL Removal | | 24b. DATE 8/7/54 | | 24c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery | | 24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo. | | | |
| DATE REC'D BY LOCAL REG. AUG 7 1954 | | REGISTRAR'S SIGNATURE J. Earl Smith M.D. | | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS G. Wade Granberry 4202 Finney | | | | |

E.C. (Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed *Melvin E. Gre*.....

Licensed Embalmer No. *44*.....
P. O. Address *St Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.