

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35754**  
Registrar's No. **8786**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>St. Louis</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1813a East Prairie Ave.</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
STREET ADDRESS (If rural, give location)		<b>1813a East Prairie Ave.</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>MAE</b>	b. (Middle) <b>A.</b>	c. (Last) <b>MOSLANK</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Sep. 26 1954</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>Nov. 3, 1884</b>	9. AGE (In years last birthday) <b>69</b>	IF UNDER 1 YEAR Months	IF UNDER 1 HR. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>0</b>
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13a. FATHER'S NAME <b>Patrick J. Lynch</b>	13b. MOTHER'S MAIDEN NAME <b>Francis Nuelle</b>	14. NAME OF HUSBAND OR WIFE <b>John Moslank</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>John R. Lynch</b>	ADDRESS <b>120 DeSmet Dr. Florissant, Mo.</b>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Apoplexy (left cerebral hemorrhage)</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sept 24th. 54</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertensive Cerebrovascular Disease</b> DUE TO (c) <b>(dbr)</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <b>St Louis Mo</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>334X</b>
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22. I hereby certify that I attended the deceased from **Dec 7, 1953**, to **Sept 26, 1954**, that I last saw the deceased alive on **Sept 25, 1954**, and that death occurred at **7:55A.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Alfred J. Macintosh</b>	23b. ADDRESS <b>2739 NO Grand</b>	23c. DATE SIGNED <b>9-27-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Sep. 29, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>SEP 27 1954</b>	REGISTRAR'S SIGNATURE <b>Carl Smith MO</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Kriegshauser</b>	ADDRESS <b>4228 S. Kingshighway Bl.</b>
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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 *Erwin A. M. Gerhardt*.....

Licensed Embalmer No... *302*

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