

FILED MAR 10 1955

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (In this place) <u>1 1/2 hrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN _____		4010	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Johns Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1007 Prigge Ave.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Infant</u>			b. (Middle) _____			c. (Last) <u>Moses</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 16, 1955</u>							
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>		8. DATE OF BIRTH <u>Feb. 15, 1955</u>	9. AGE (In years) (Months) (Days) (Hours) (Min.) last birthday) <u>11</u>		
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) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>0</u>	
13a. FATHER'S NAME <u>Vincent Moses</u>			13b. MOTHER'S MAIDEN NAME <u>Catherine Sprock</u>			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)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Vincent Moses</u> ADDRESS <u>1007 Prigge Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				MEDICAL CERTIFICATION			
<p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cataleptasia</u></p> <p>ANTECEDENT CAUSES</p> <p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p> <p>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</p> <p>DUE TO (b) <u>Prematurity - 34 weeks gestation</u></p> <p>DUE TO (c) _____</p> <p>II. OTHER SIGNIFICANT CONDITIONS</p> <p>Conditions contributing to the death but not related to the disease or condition causing death.</p>				INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>7.625</u>			
22. I hereby certify that I attended the deceased from <u>2-15</u> , 19 <u>55</u> , to <u>2-16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2-16</u> , 19 <u>55</u> , and that death occurred at <u>9:35 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>A. J. Eschwege M.D.</u>				23b. ADDRESS <u>457 1/2 Kingshighway</u>		23c. DATE SIGNED <u>2-16-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>2-18-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>FEB 16 1955</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bopp Funeral Home</u> ADDRESS <u>Kirkwood, Missouri</u>			

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 _____

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No. _____

Not embalmed.

Signed _____

Rolland H. Byrnes

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.