

FILED JAN 6 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **42436**  
Registrar's No. **11227**

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

|   |  |   |  |                                  |  |
|---|--|---|--|----------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |  |                                  |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> |  | c. LENGTH OF STAY (in this place) <b>Life</b>   |  | c. CITY OR TOWN <b>St. Louis</b> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis State Hospital</b>                       |  | e. STREET ADDRESS (If rural, give location) <b>5400 Arsenal Street</b>  |  |                                  |  |

|   |  |                                   |  |   |  |
|---|--|-----------------------------------|--|---|--|
| 3. NAME OF DECEASED<br>(Type or Print) <b>Martha Moss</b>   |  |                                   | 4. DATE OF DEATH <b>December 21 1955</b> |   |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>White</b>     |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>          |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House leeper</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY |  | 8. DATE OF BIRTH <b>October 4, 1897</b>                                       |  |
|   |  |                                   |  | 9. AGE (In years last birthday) <b>57 58</b>                                  |  |
|   |  |                                   |  | 11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b> |  |
|   |  |                                   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                    |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 13a. FATHER'S NAME <b>Thomas Moss</b>                                       |  | 13b. MOTHER'S MAIDEN NAME <b>Catherine Fergus</b> |  | 14. NAME OF HUSBAND OR WIFE <b>None</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> |  | 16. SOCIAL SECURITY NO. <b>None</b>               |  | 17. INFORMANT'S SIGNATURE OR NAME <b>George A. Moss</b> ADDRESS <b>1822a Cass Av</b> |  |

|   |  |  |                       |  |  |  |  |
|---|--|--|-----------------------|--|--|--|--|
| 18. CAUSE OF DEATH<br>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) <b>Broncho-pneumonia, right</b>  |  |  | DUE TO (b) _____      |  |  | <b>2 wks.</b>  |  |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.                            |  |  | DUE TO (c) _____      |  |  |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Arteriosclerotic heart disease</b> |  |  |                       |  |  | <b>1 yr.</b>   |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION <b>491x</b> |                       |  |  | 20. AUTOPSY? YES <input checked="" 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?                      |  |

22. I hereby certify that I attended the deceased from **2-13**, **1955**, to **12-21**, **1955**, that I last saw the deceased alive on **12-21**, **1955**, and that death occurred at **8:45p. m.**, from the causes and on the date stated above.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 23a. SIGNATURE <b>Anna Hyman MD</b> (Degree or title)   |  | 23b. ADDRESS <b>5400 Arsenal Street</b> |  | 23c. DATE SIGNED <b>12-22-55</b>                                  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> |  | 24b. DATE <b>12-23-55</b>               |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>                 |  |
|   |  |   |  | 24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b> |  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| DATE REC'D BY LOCAL REG. <b>DEC 22 1955</b> |  | REGISTRAR'S SIGNATURE <b>[Signature]</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Brockland Undertaking Co</b> ADDRESS <b>1827 Hogan St</b> |  |
|---|--|--|--|---|--|

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

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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.....  
Signature of Student Embalmer

Signed *Robert M. Murray*.....  
3749

Licensed Embalmer No.....

P. O. Address *St. Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.