

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29811**

FILED AUG 30 1957

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 7044	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 3 days		c. CITY OR TOWN Breckendrige Hill		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mo. Baptist Hospital				e. STREET ADDRESS (If rural, give location) 9418-Tudor Avenue			
3. NAME OF DECEASED (Type or Print) a. (First) James			b. (Middle) _____		c. (Last) Mosier		4. DATE OF DEATH (Month) (Day) (Year) July 28, 1957
5. SEX <input type="checkbox"/> Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Feb. 22, 1889		9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanist		10b. KIND OF BUSINESS OR INDUSTRY Wagner Elec. Co.		11. BIRTHPLACE (City and State or Foreign Country) Old Mines, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Charles Mosier		13b. MOTHER'S MAIDEN NAME Martha Tebeau		14. NAME OF HUSBAND OR WIFE Katherine E. Mosier			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 490-01-5985		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Katherine E. Mosier 9418-Tudor Ave.			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pericarditis of heart ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Uremia DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 581.0				INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs 1 wk	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
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) _____		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 2/8/1956 , to 7/28 , 1957, that I last saw the deceased alive on 7/28/1957 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) H. W. Moore M.D.				23b. ADDRESS 2438 Woodson Rd		23c. DATE SIGNED 7/29/57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7-31-57	24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery		24d. LOCATION (City, town, or county) (State) Pagedale, Mo.		
DATE REC'D BY LOCAL REG. JUL 29 1957		REGISTRAR'S SIGNATURE Charles Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE William Overland		ADDRESS 2504-Woodson Rd-Overland-14-Mo.	

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 *Loren E. Percy*.....

Licensed Embalmer No. *40*.....

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.**