Health, Welfare Public Service

300 1-56

XC # 16214973
SL # 14376

FILED OCT 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 33909 8942

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH
a. COUNTY ST. LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL — Length of stay in 1b 54 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY ST. LOUIS
c. CITY OR TOWN ST. LOUIS — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 3127 EVANS AVE. — Reside on Farm Yes ☐ No ☒

35 2219

3. NAME OF DECEASED (Type or print) First AMOS Middle Last MOSBY
4. DATE OF DEATH Month Day Year 9-21-57
5. SEX MALE
6. COLOR OR RACE NEGRO
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 5-18-96
9. AGE (In years last birthday) 61 — 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) LABORER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) MONROE CO., MISSISSIPPI
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME CHARLIE MOSBY
14. MOTHER'S MAIDEN NAME UNKNOWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES — (If yes, give war or dates of service) WW 1
16. SOCIAL SECURITY NO. UNKNOWN
17. INFORMANT Address VA HOSP. RECORDS 915 N GRAND ST LOUIS MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASPIRATION OBSTRUCTION TRACHEA — INTERVAL BETWEEN ONSET AND DEATH MINUTES
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) PREVIOUS CEREBRAL VASCULAR ACCIDENT — 3 MONTHS
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 331X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I VA attended the deceased from 7-29-57 to 9-21-57 and last saw alive on 9-21-57
Death occurred at 5:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) H. JOHNSON M. D.
22b. ADDRESS VAH. ST. LOUIS, MO.
22c. DATE SIGNED 9-21-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE Sept. 27, 1957
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) Okolona, (State) Miss.

24. FUNERAL DIRECTOR J. H. RANDLE & SON ADDRESS 3133 Bell Ave.
25. DATE RECD. BY LOCAL REG. SEP 24 57
26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Esther K. Harris

Licensed Embalmer No. 44

P. O. Address 4481 Wash

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