

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-046085

STATE FILE NUMBER

FILED JAN 14 1959

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 12683

300  
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Overland 426 <sup>th</sup>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Barnes Hospital		d. STREET ADDRESS (If outside, give location) 9530 Minerva	
3. NAME OF DECEASED (Type or print) First Middle Last LeRoy Charles Mosher		4. DATE OF DEATH Month Day Year Dec. 29, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1925
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Accounting	11. BIRTHPLACE (City and state or country) Lansing, Michigan
13a. FATHER'S NAME Clair Allen Mosher		13b. MOTHER'S MAIDEN NAME Florence Fruin	12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 375-20-5679	17. INFORMANT Eleanor Mosher, 9530 Minerva, Overland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation			INTERVAL BETWEEN ONSET AND DEATH 30 min
DUE TO (b) Epilepsy; Grand mal type			20 years
DUE TO (c) Idiopathic			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 3531			
19a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? 1 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. Dec. 29, 1958 p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Pt. had convulsion and buried nostrils in pillow.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 29 Home	
20f. CITY, TOWN, OR LOCATION Overland		COUNTY STATE Shannon Mo.	
21. I attended the deceased from 1952 to Date and last saw him alive on July 1957 Death occurred at 1:00 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE E. W. Parsons, M.D.		22b. ADDRESS 457 N. Kings Highway	
22c. DATE SIGNED 12/30/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-2-1959	
23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		23d. LOCATION (City, town, or county) (State) St. Ann, Missouri	
24. FUNERAL DIRECTOR Baumann Bros. Inc. Overland, Mo.		25. DATE RECD. BY LOCAL REG. DEC 30 58	
26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related

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 *David C. Gibson* .....

Licensed Embalmer No. *3654* .....  
P. O. Address *Oakland* .....

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.