

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011223
STATE FILE NUMBER
2080

Health,
Welfare
Public
Service

MAR 17 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

300
1-57

0
8
All diseases in Part I must be causally related.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>City of St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Madison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Venice</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hospital</u> Length of stay in 1b <u>20 days</u>		d. STREET ADDRESS (If outside, give location) <u>205 Linberg</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle _____ Last <u>Moss</u>			4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>59</u>
5. SEX <u>male 2</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1905</u>
9. AGE (In years less birthday) <u>53</u>	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) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Foundry</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>George Moss</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Lewis</u>	
14. NAME OF HUSBAND OR WIFE <u>Juanita Moss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>497-05-6078</u>	17. INFORMANT Address <u>Juanita Moss-205 Linberg, Venice, Ill.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Respiratory Paralysis</u> DUE TO (c) <u>Guillan Barre Syndrome</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>4 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>364X</u>			19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>n/a</u>		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	<u>n/a</u>		
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>n/a</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>n/a</u>	
21. I attended the deceased from <u>Feb 6, 1959</u> to <u>Feb 26, 1959</u> and last saw ^{him} <u>him</u> alive on <u>Feb 26, 1959</u> Death occurred at <u>4:20</u> A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert Rabin M.D.</u> (Degree or title)		22b. ADDRESS <u>216 S. Kingshighway St. Louis</u>	22c. DATE SIGNED <u>2/26/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>2-27-59</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or country) (State) <u>East St. Louis, Ill.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Marshall Funeral Home-E. St. Louis, Ill.</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 27 '59</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>

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 *Thomas M. Doherty*

Licensed Embalmer No. 4479.....
P. O. Address East St. Louis, Ill.....

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.