

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022215

STATE FILE NUMBER

JUN 19 1959 Registration District No. 217 Primary Registration District No. 5787 Registrar's No. 50

300
1-57

1. PLACE OF DEATH a. COUNTY Mississippi			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Mississippi		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Tywapity		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Charleston		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Route 3		Length of stay in 1b 22 yrs.	d. STREET ADDRESS (If outside, give location) 067 0 Route 3		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First George Middle Mosley Last Mosley			4. DATE OF DEATH Month June Day 8 Year 1959		
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1887		9. AGE (In years at birthday) 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (City and state or country) Monroe, La.	
13a. FATHER'S NAME George Mosley		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Unknown	
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.		17. INFORMANT Address Mrs. L.M. Crawford, Cairo, Ill.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Presumed to be natural causes (Coroner of Miss. Co. Notified) DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7954					INTERVAL BETWEEN ONSET AND DEATH
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.)		
20c. TIME OF INJURY Hour * Month, Day, Year a.m. p.m.					
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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at 6:00 6P m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Dorothy B. Hathorn Local Registrar			22b. ADDRESS Charleston Mo.		22c. DATE SIGNED 6-12-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 13, 1959	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		23d. LOCATION (City, town, or county) (State) Charleston Miss. Mo.
24. FUNERAL DIRECTOR ADDRESS L.R. Sparks Charleston, Mo.			25. DATE RECD. BY LOCAL REG. 6-12-59		26. REGISTRAR'S SIGNATURE Dorothy B. Hathorn

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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JUN 19 1959

Date Filed 6-17-59

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 Oliver H. Holmes

Licensed Embalmer No. 4190
P. O. Address Charleston

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.