

**URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS SEP 21 1959**

**59-034124**  
 STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 8382**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b <b>22 DAYS</b>	c. CITY OR TOWN <b>ST. LOUIS</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Vet. Adm. Hosp. 915 N.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5222A MORGANFORD ROAD</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN M. MOSEY</b>			4. DATE OF DEATH Month Day Year <b>9/9/59</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/25/83</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>76</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>JOHN M. MOSEY</b>		13b. MOTHER'S MAIDEN NAME <b>FRANCES SKROSKA</b>	14. NAME OF HUSBAND OR WIFE - - - - -
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW-I</b>		16. SOCIAL SECURITY NO. <b>493-24-5659a</b>	17. INFORMANT Address <b>VAH, 915 NO. GRAND AVE., ST. LOUIS, MO.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>SEGMENTAL MESENTERIC THROMBOSIS DUE TO</b> IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>28 HOURS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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) <b>ACTIVE PULMONARY TUBERCULOSIS, DIABETES</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	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 a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <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. attended the deceased from <b>8/18/59</b> , to <b>9/9/59</b> and last saw <del>him</del> <sup>her</sup> alive on <b>9/9/59</b> Death occurred at <b>9:45 AM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Franklin H. Pfeiffer</i> <b>FRANKLIN H. PFEIFFER M.D.</b>		22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>	22c. DATE SIGNED <b>9/9/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Sep. 12, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>S/S Peter &amp; Paul Cem</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S.Kingshighway</b>		25. DATE RECD. BY LOCAL REG. <b>SEP 10 '59</b>	26. REGISTRAR'S SIGNATURE <i>Frank Smith M.D.</i>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

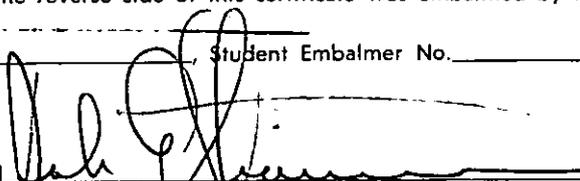
BY AFFIDAVIT OF

DEC 10 1959

**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  \_\_\_\_\_

Licensed Embalmer No. 4533

P. O. Address \_\_\_\_\_

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.