

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037898

FILED VS OCT 19 1959

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **9230**

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</b>		Length of stay in 1b <b>40 years</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>Homer G. Phillips</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2616 Stoddard</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Mosley</b> Last <b>Mosley</b>				4. DATE OF DEATH Month <b>10</b> Day <b>8</b> Year <b>59</b>															
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3-15-1890</b>		9. AGE (last birthday) <b>69</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired Laborer</b>		11. BIRTHPLACE (City and state or country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>											
13a. FATHER'S NAME <b>Andrew Mosley</b>				13b. MOTHER'S MAIDEN NAME <b>Scharlett Mosley</b>				14. NAME OF HUSBAND OR WIFE <b>none</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. _____		17. INFORMANT <b>Robert Lee Mosley 2616<sup>a</sup> Stoddard</b>				Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>									
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <b>443X</b>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic Heart Disease with Acute Subendocardial Ischemia</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 type="checkbox"/> NO <input checked="" 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. I attended the deceased from <b>9-21-59</b> to <b>10-5-59</b> and last saw him alive on <b>10-5-59</b> Death occurred at <b>12:15</b> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE (Degree or title) <b>Edward B. Williams M.D.</b>						22b. ADDRESS <b>2601 N. Whittier St.</b>				22c. DATE SIGNED <b>10-6-59</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>10 12 59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Father Dixon</b>				23d. LOCATION (City, town, or county) (State) <b>Kirkwood Mo</b>											
24. FUNERAL DIRECTOR <b>A. H. Burks 3506 Franklin</b>				25. DATE RECD. BY LOCAL REG. <b>OCT 8 '59</b>		26. REGISTRAR'S SIGNATURE <b>Loal Smith M.D.</b>													

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Leroy M. Bennett

Licensed Embalmer No. 4523

P. O. Address #251 Washington

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.