

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS JAN - 4 1960 317

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3465 STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 3465

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>		Length of stay in lb <b>1 day</b>		c. CITY OR TOWN <b>Webster Groves</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>St. Marys Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1206 Pine Tree Lane</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NOEL</b> Middle <b>MOSIER</b> Last				4. DATE OF DEATH Month <b>Dec.</b> Day <b>26</b> Year <b>1959</b>				
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>4-29-95</b>	9. AGE (last birthday) <b>64</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Coal</b>		11. BIRTHPLACE (City and state or country) <b>Sullivan Co., Ind.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>John Mosier</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Raines</b>			14. NAME OF HUSBAND OR WIFE <b>Nelle Mosier</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>480-07-0853</b>		17. INFORMANT Address <b>R. J. Peterson, 315 Parkwood Rd.</b>			
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>Mesenteric thrombosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</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)						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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>St. Louis, Ind.</b>		COUNTY		STATE
21. I attended the deceased from <b>1958</b> to <b>12/26/59</b> and last saw him alive on <b>12/26/59</b> Death occurred at <b>3:45 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>W. J. Watson</b> (Degree or title)				22b. ADDRESS <b>8059 WATSON Rd</b>		22c. DATE SIGNED <b>12/27/59</b> (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>12-28-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Center Ridge Cem.</b>		23d. LOCATION (City, town, or county) <b>Sullivan, Ind.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Parker-Aldrich, Webster Groves</b>				25. DATE RECD. BY LOCAL REG. <b>12-27-59</b>		26. REGISTRAR'S SIGNATURE <b>John B. Murphy</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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Leslie Welch*

Licensed Embalmer No. 4395

P. O. Address Walter Gro

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.