

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-027791
STATE FILE NUMBER

AMENDED

Registration District No. 217 Primary Registration District No. 500 Registrar's No. 1844

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Winchester | | c. CITY OR TOWN Lemay | |
| Length of stay in 1b 1-yr. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Manchester Nurs. Home | | d. STREET ADDRESS (If outside, give location) 2660 Jonathan Dr. | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

| | | | | | |
|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Christian Middle Moser Last Moser | | | 4. DATE OF DEATH Month July Day 2, Year 1961 | | |
|---|--|--|--|--|--|

| | | | | | | |
|-----------------------|----------------------------------|---|------------------------------------|-------------------------------------|--|--|
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12/1/77 | 9. AGE (last birthday) 83 | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> | IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
|-----------------------|----------------------------------|---|------------------------------------|-------------------------------------|--|--|

| | | | |
|---|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Lather | 10b. KIND OF BUSINESS OR INDUSTRY (retired) | 11. BIRTHPLACE (City and state or country) St. Louis, Missouri | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
|---|---|--|--|

| | | |
|--|---|--|
| 13a. FATHER'S NAME Matthew Moser | 13b. MOTHER'S MAIDEN NAME unknown | 14. NAME OF HUSBAND OR WIFE Eleanor E. Moser |
|--|---|--|

| | | | |
|--|---|--|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown | 16. SOCIAL SECURITY NO. unknown | 17. INFORMANT Mrs. Anna Schultz - 8833 Shady Grove | Address |
|--|---|--|---------|

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH ? |
| IMMEDIATE CAUSE (a) CARDIO-VASCULAR DISEASE | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) SENILITY | | |
| DUE TO (c) | | |

| | |
|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) NONE | 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 <input type="checkbox"/> s.m. <input type="checkbox"/> p.m. <input type="checkbox"/> | 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 **APRIL 15, 1961** to **JULY 2, 1961** and last saw her/him alive on **JULY 2, 1961**
Death occurred at **6:18 P.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | |
|--|-------------------|-------------------------------------|---|
| 22a. SIGNATURE B.R. Loving, M.D. | (Degree or title) | 22b. ADDRESS BALLWIN, MO. | 22c. DATE SIGNED July 3, 1961 |
|--|-------------------|-------------------------------------|---|

| | | | |
|--|----------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE July 5, 1961 | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri |
|--|----------------------------------|--|--|

| | | | |
|--|---------|---|---|
| 24. FUNERAL DIRECTOR WACKER-HELDERLE-3634 Gravois Ave. | ADDRESS | 25. DATE RECD. BY LOCAL REG. 7-3-61 | 26. REGISTRAR'S SIGNATURE <i>John C. Murphy M.D.</i> |
|--|---------|---|---|

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 Lawrence M. B. Ho

Licensed Embalmer No. 4375
P. O. Address Paris 23, W

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.