

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-004258

STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 405

FILED JAN 25 1962

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|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Homer G. Phillips</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo</b> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN<br><b>St. Louis</b>                |  | c. CITY OR TOWN<br><b>St. Louis</b>   |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION<br><b>Homer Phillips</b> |  | d. STREET ADDRESS (If outside, give location)<br><b>3602 Marcus</b>   |  |

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|---|--|--|---|--|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Sam Mosley</b> |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>1 7 62</b> |  |  |  |
|---|--|--|---|--|--|--|

|                       |                                  |  |                                     |                                     |                                |                               |
|-----------------------|----------------------------------|--|-------------------------------------|-------------------------------------|--------------------------------|-------------------------------|
| 5. SEX<br><b>Male</b> | 6. COLOR OR RACE<br><b>Negro</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/22/10</b> | 9. AGE (last birthday)<br><b>51</b> | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HR.<br>Hours Min. |
|-----------------------|----------------------------------|--|-------------------------------------|-------------------------------------|--------------------------------|-------------------------------|

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|--|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mo Pacific</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b> | 11. BIRTHPLACE (City and state or country)<br><b>Enid Miss</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b> |
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| 13a. FATHER'S NAME<br><b>Ben Mosley</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Robie J. Nelson</b> | 14. NAME OF HUSBAND OR WIFE |
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|   |                         |   |                                 |
|---|-------------------------|---|---------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b> | 16. SOCIAL SECURITY NO. | 17. INFORMANT<br><b>Mary A. Singleton</b> | Address<br><b>5617 Cabbanne</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Hypertrophic Myocarditis</b><br>DUE TO (b) <b>Coronary Sclerosis</b><br>DUE TO (c) <b>4201</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
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| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
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| 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.) |
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| 20c. TIME OF INJURY<br>Hour a.m. p.m.<br>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<br>COUNTY STATE |
|---|--|--|--|

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

|  |                                   |                                    |
|--|-----------------------------------|------------------------------------|
| 22a. SIGNATURE (Degree or title)<br><i>Paul M. [Signature]</i> | 22b. ADDRESS<br><b>1300 Clair</b> | 22c. DATE SIGNED<br><b>2-10-62</b> |
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|   |                            |  |  |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 23b. DATE<br><b>1/2/62</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington Park</b> | 23d. LOCATION (City, town, or county) (State)<br><b>5500 Brown St. Louis Co Mo</b> |
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|   |                               |  |   |
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| 24. FUNERAL DIRECTOR<br><b>Whitney Funeral Home</b> | ADDRESS<br><b>3882 Delmar</b> | 25. DATE RECD. BY LOCAL REG.<br><b>JAN 10 1962</b> | 26. REGISTRAR'S SIGNATURE<br><i>Paul Smith M.D.</i> |
|---|-------------------------------|--|---|

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTead OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 AFFIDAVIT OF  
 SHOULD READ  
 ITEM NO.

**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 F. L. Green

Licensed Embalmer No. 1963

P. O. Address 4214 W. 10th

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.