

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-008499

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1871**

FILED FEB 23 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1	
2	219
3	2
4	2
5	1
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10	
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12	75-0
13	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		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. LOUIS CITY HOSP #1</b>		d. STREET ADDRESS (If outside, give location) <b>4457 Enright</b>	
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)		4. DATE OF DEATH	
First Middle Last <b>JAMES MOSS</b>		Month Day Year <b>2 11 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</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>10-28-1899</b>
9. AGE (last birthday) <b>62</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) <b>Elevator Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	11. BIRTHPLACE (City and state or country) <b>Morgenfield, Ky.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Clarence Moss</b>		13b. MOTHER'S MAIDEN NAME <b>Eliza Harris</b>	
14. NAME OF HUSBAND OR WIFE <b>Sadie Moss</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>No</b>	
17. INFORMANT <b>Henry Moss 4281E, Kennerly</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>Adenocarcinoma of Stomach</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>151X</b>			
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 checked="" 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. I attended the deceased from <b>2-9-62</b> , to <b>2-11-62</b> and last saw her/him alive on <b>2-11-62</b> Death occurred at <b>5:40 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>David L. Seals, M.D.</b> (Degree or title)		22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	22c. DATE SIGNED <b>2-11-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>2-16-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Lemay, Mo.</b>
24. FUNERAL DIRECTOR <b>Ed Joann</b> ADDRESS <b>1221 North Grand</b>		25. DATE RECD. BY LOCAL REG. <b>FEB 14 1962</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>

**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

*Melvin Blackburn*

Licensed Embalmer No.

*3962*

P. O. Address

*1271 N Grand Ave*

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.