

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

12048

**1. PLACE OF DEATH**

County..... Registration District No. 791  
Township..... Primary Registration District No. 11003  
City St. Louis Mo. (No. 1419) So. 7th St. St. \_\_\_\_\_ Ward)

File No. \_\_\_\_\_  
Registered No. 3303

**2. FULL NAME** Lysle Earl Moses

(a) Residence. No. 1419 So. 7th. St. 23 Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF XXXX

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 20 1927

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>3</u>	<u>10</u>	<u>23</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work At Home  
(b) General nature of industry, business, or establishment in which employed (or employer) XXX 107A  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Desoto  
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Manuel Moses  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Bonne Terre  
(STATE OR COUNTRY) Missouri  
12. MAIDEN NAME OF MOTHER Thelma Filkins  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Desoto  
(STATE OR COUNTRY) Missouri

14. INFORMANT Manuel Moses  
(Address) 1419 So. 7th

15. FILED 16 1931 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/13/ 19 31

17. I HEREBY CERTIFY, That I attended deceased from Feb 5<sup>th</sup>, 1931 to March 13, 1931, that I last saw h. alive on March 12, 1931, and that death occurred, on the date stated above, at 10:50 A. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

PERTUSSIS + ACUTE CARDIAC DILATATION

CONTRIBUTORY UNRESOLVED MEASLES + BRONCHO-PNEUMONIA Secondary  
(SECONDARY) (duration) 2 yrs. 10 mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH X

DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS X

(Signed) Walter E. Frank, M. D.

3-14-31 (Address) 1405 S. Broadway

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Bonne Terre Missouri DATE OF BURIAL 3/15/ 19 31

20. UNDERTAKER Wm Langdon ADDRESS 1631 Missouri

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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