

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.

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

Do not use this space.

NOV 9 1935

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis* (No. *11044*)

Registration District No. *1791*
Primary Registration District No. *1003*

File No. *34686*
Registered No. *9167*
St. Ward)

2. FULL NAME

Mamie Moses

(a) Residence, No. *325* St. *Antelope* Ward. *8*
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da How long in U. S., if of foreign birth? yrs. mos. da. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>female</i>	4. COLOR OR RACE <i>white</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Divorced</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Henry Moses</i>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Feb. 19, 1882</i>				
7. AGE	YEARS <i>53</i>	MONTHS <i>8</i>	DAYS <i>11</i>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Book</i>			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis Mo</i>				
MOTHER	13. NAME <i>Henry Jeff</i>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Germany</i>			
	15. MAIDEN NAME <i>Mary ?</i>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Germany</i>			
17. INFORMANT (ADDRESS) <i>Joseph J. Clark</i>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Calvary</i> DATE <i>Nov. 4 1935</i>				
19. UNDERTAKER (ADDRESS) <i>Jos. W. Clark 1125 N. Diamond Ave.</i>				
20. FILED <i>OCT 31 1935</i> <i>J. T. Brebeck</i> Registrar				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct 30, 1935*

22. I HEREBY CERTIFY, That I attended deceased from *10/13*, 19*35*, to *10-30*, 19*35*.
I last saw *her* alive on *10-30*, 19*35*. Death is said to have occurred on the date stated above, at *6:30* p.m.
The principal cause of death and related causes of importance were as follows:
Uterine Fibroids Malignant Complete Hysterectomy 1925 Pulmonary Edema (Date of onset *1925*)
Other contributory causes of importance: *48*

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury..... 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) *A. E. Ottum*, M. D.
(Address) *City St. Louis*

