

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

44339
Do not use this space.

1. PLACE OF DEATH **St. Charles Mo.** 3 Registration District No. **756**
 (a) County **St. Charles Mo.** (b) Township **Portage De Sioux MO** Primary Registration District No. **44545997** Registered No. _____
 (c) City **West Alton** (d) Street No. **Highway #99** St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
240 (f) How long in U. S., if of foreign birth? yrs. mos. ds. _____

2. PRINT FULL NAME **Joseph C. Mosley**
 (a) Residence, No. **7446 Lyndover** St. **Maplewood, Mo.**
 (Usual place of abode; if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Cordelia Mosley**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Oct. 22, 1888**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
50	1	17		

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Electrician**
 9. Industry or business in which work was done, as 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) **Fulton Mo.**

FATHER 13. NAME **James Mosley**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

MOTHER 15. MAIDEN NAME **Unknown**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

17. INFORMANT (ADDRESS) **Cordelia Mosley 7446 Lyndover**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Maplewood MO.** DATE **Dec. 13 '38**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Jay B. Smith 7456 Manchester**

20. FILED **Dec 15 1938** **C. D. Barnard** Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Dec. 9th 1938, 19**

22. I HEREBY CERTIFY That I attended deceased from **Held Inquest**, 19..... to **Dec. 10th 1938**, 19.....
 I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at **10 PM** m.
 The principal cause of death and related causes of importance were as follows:
Skull fracture and hemorrhage of brain.
Fracture both jaws.
immediate death.
Passenger in automobile.

Other contributory causes of importance: _____

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? **accident** Date of injury **12-9-38**
 Where did injury occur? **Highway 99 West Alton Mo.**
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
Public Highway.
 Manner of injury **Flew from car into ditch.**
 Nature of injury **Head Injuries.**

24. Was disease or injury in any way related to occupation of deceased? **no**
 If so, specify **John Bure**
 (Signed) **John Bure** **4**
Cor. St. Charles Co. Mo.

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.

71025

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

Registered Apprentice No., working under my personal supervision.

Signed

Licensed Embalmer No.

P. O. Address

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County St Charles Registration District No. 95-6
 (b) Township Partridge de Dion Primary Registration District No. 5997
 (c) City..... (d) Street No..... St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. d. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Joseph C Mosley St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

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

7. AGE YEARS 30 MONTHS 1 DAYS 19 If LESS than 1 day,hrs. ormin.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as 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)

FATHER 13. NAME

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE..... DATE..... 19.....

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED..... 19..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 9 1938

22. I HEREBY CERTIFY, That I attended deceased from 19..... to....., 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Skull Fract. + Hemorrhage
Brain
Fracture both jaws
Immediate death
passenger in auto

Other contributory causes of importance:

Collision with fixed object.

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 John H. Busc
 (Signed) St. Charles M.D.
 (Address) St. Charles

SUPPLEMENT

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 CAUSE OF DEATH is most important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

