

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 201

Primary Registration District No. \_\_\_\_\_

Registrar's No. 10675

1. PLACE OF DEATH: 1003 2

(a) County \_\_\_\_\_

(b) City or town St. Louis

(c) Name of hospital or institution: 4572 Red Bud Ave  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Mo. (b) County \_\_\_\_\_

(c) City or town St. Louis 9  
(If outside city or town limits, write "RURAL")

(d) Street No. 4572 Red Bud Ave  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 50 years \_\_\_\_\_ years

3. (a) PRINT FULL NAME ANNA MARY MOSBERGER

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife JACOB MOSBERGER 6. (c) Age of husband or wife if alive 81 years

7. Birth date of deceased Jan 19 Th 1858  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 12 year 39 hour 4 minute 0 M.

21. I hereby certify that I attended the deceased from Aug 1939 19\_\_\_\_, to Dec 12 1939 19\_\_\_\_; that I last saw her alive on 12 12 39 19\_\_\_\_; and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

81 ----- 10 - 23 - \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Germany  
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

12. Name Heman Nolte

13. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Not known

15. Birthplace Germany  
(City, town, or county) (State or foreign country)

Immediate cause of death Apoplexy | 12, Dec 39 Duration

Due to High Blood Pressure with cerebral embolism

Due to \_\_\_\_\_

Other conditions Arteriosclerosis, Mitral Regurgitation, Chronic nephritis, Anemia

MOTHER FATHER

16. (a) Informant's own signature Kath Mosberger

(b) Address 4572 Red Bud Ave 1939

17. (a) Burial (b) Date thereof Dec 15 Th  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Edward Koch

(b) Address 3616 N. 14 Th Str

19. (a) DEC 14 1939 (b) J. F. Breda  
(Date of local registration) (Registrar's signature)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature B. J. Wenzel (M. D. or other)

Address 1875 Madison Date signed 12/15/39

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.

APR 23 1970

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**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.....

.....  
working under my personal supervision.

Registered Apprentice No. ....

Signed.....

*B. W. ...*

Licensed Embalmer No. ....

1591

P. O. Address.....

4106 Bestam

**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.**