

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.

Registration District No. 791

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH: ICUS JAN 12 1940
 (a) County _____
 (b) City St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: No. Baptist Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution HOSPITAL
 (Specify whether _____)
 In this community 11 days
 (years, months or days)

3. (a) PRINT FULL NAME WILLIAM MOSLEY. 240
 3. (b) If veteran, name war None
 3. (c) Social Security No. None

4. Sex Male 5. Color or race White
 6. (a) ~~Single, widowed, married,~~ Married

6. (b) Name of ~~husband or~~ wife Alta Mae Mosley,
 6. (c) Age of ~~husband or~~ wife if alive 49 years

7. Birth date of deceased April 1, 1886.
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 8 12 _____ hr. _____ min.

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

10. Usual occupation Merchant

11. Industry or business own buisness.

MOTHER FATHER { 12. Name James Mosley.

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

14. Maiden name Dont know

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

16. (a) Informant's own signature Mrs. Alta Mae Mosley

(b) Address 5955 Romaine Place.

17. (a) Burial (b) Date thereof 12-16-1939
 (Burial, _____) (Month) (Day) (Year)

(c) Place: burial Mt. Lebanon Cemetery.

18. (a) Signature of funeral director Geo. L. Pleitsch, Inc.

(b) Address 5966-68 Boston Ave. St. Louis

19. (a) DEC 15 1939 (b) _____
 (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri. (b) County _____
 (c) City St. Louis, 6
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5955 Romaine Place.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 13
 year 1939. hour 11 minute 20 PM.

21. I hereby certify that I attended the deceased from 10-25-39
 _____, 19____, to Dec-13- 1939

that I last saw him alive on Dec-13-39, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
acute nephritis caused by strep
cardiac decompensation
 Due to myocardia chronic

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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 _____

28. Signature Clarence J. Damm (M. D. or other) _____
 Address 1927 2nd Union Date signed 12-17-39

Dr. C. L. Brown
1927 Union Ave
10 to 12

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.....

Leonard W. Kraeger....., Registered Apprentice No.....
working under my personal supervision.

Signed.....*Leonard W. Kraeger*.....
Licensed Embalmer No.....*2678*.....
P. O. Address.....*St. Louis, Mo.*.....

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.