

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No.

1. PLACE OF DEATH:

(a) County 3
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
N. Side Little Sisters of the Poor
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 years
(Specify whether years, months or days)
In this community 50 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis.
(If outside city or town limits, write "RURAL")
(d) Street No. 3225 N. Florissant Ave. 20
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 50 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 19,
year 1940 hour 2:00 minute 9. A.M.

21. I hereby certify that I attended the deceased from Dec. 5, 1940 to Dec. 19, 1940
that I last saw h. alive on Dec. 18, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration 2 weeks

Chronic Myocarditis

Due to _____

Due to _____

Other conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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 _____

23. Signature Anthony A. Piekarski (M. D. or other) M.D.
Address 1525 a Cass Ave. Date signed 12/19/40

3. (a) PRINT FULL NAME Catherine Moss

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed.

6. (b) Name of husband or wife Thomas Moss (deceased) 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: April 26 1870
(Month) (Day) (Year)

8. AGE: Years 70. Months 7 Days 23 If less than one day _____ hr. _____ min.

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

10. Usual occupation Houswork

11. Industry or business _____

12. Name Thomas Ferguson

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

14. Maiden name Sabina Quinn.

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

16. (a) Informant Mrs. Mary Moran

(b) Address 1406 W. 9th St.

17. (a) Burial. (b) Date thereof Dec. 20, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Brookland Und. Co.

(b) Address 1827 Hogan St.

19. (a) DEC 19 1940 (b) J. J. Bredekamp
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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: Albert G. Hays

Licensed Embalmer No. 2971

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, fact should be so stated above.