No. 2
-9-4-41
-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22528

FILED JUL 15 1944

Registration District No. 3 / 1

Primary Registration District No. 3069

Registrar's No. 1463

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Marys Hospital - 6420 Clayton Rd
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution From Birth (Specify whether
In this community 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County ~~St Louis~~

(c) City or town St Louis 000
(If outside city or town limits, write "RURAL") 17

(d) Street No. 5202 Delor St
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Richard Thomas Moss

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased July (Month) - 6 (Day) - 1944 (Year)

8. AGE:	Years	Months	Days	If less than one day
X	0	0	0	19 hr. 55 min.

9. Birthplace St Louis Co. (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Child

11. Industry or business

FATHER
12. Name Nels Carlos Moss
13. Birthplace Mount Vernon (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Dolores Marie Almon
15. Birthplace St Louis (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Nels Carlos Moss

(b) Address 5202 Delor St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-7-44 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J Donnelly

(b) Address 3840 Lindell Blvd

19. (a) JUL 8 - 1944 (Date received local registrar) (b) E. D. McGavran, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6th year 1944 hour 8 45 minute P M.

21. I hereby certify that I attended the deceased from July 6 1 50 am 1944, to July 6 1944 that I last saw him alive on July 6th 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Intra Cranial Hemorrhage

Due to Pre Mature Infant 7½ Months - Difficult Delivery

Due to Shoulder Presentation

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 160a

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature John B. O'Neill (M. D. or other)

Address 1222 Missouri Theatre Date signed 7/7/44

(Licensed Embalmer's Statement on Reverse Side)

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 w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.