

FILED AUG 3 1945
Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis, Mo.**
(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: **Homer G. Phillips Hospital 0**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 days**
In this community **12 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis, 17-235**
(If outside city or town limits, write "RURAL")
(d) Street No. **1412 R. Cass Avenue 9**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **William Mosley**

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

4. Sex **Male 2** 5. Color or race **Colored** 6. (a) Single, widowed, divorced, **Single** married.

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

7. Birth date of deceased **March 4, 1890**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
55 4 12 hr. min.

9. Birthplace **Miss. 1**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name **George Mosley**
13. Birthplace **Miss. 1**
(City, town, or county) (State or foreign country)
14. Maiden name **Eliza Davis**
15. Birthplace **Miss. 1**
(City, town, or county) (State or foreign country)

16. (a) Informant **Shirley M. Smith**
(b) Address **2601 N. Whittier**

17. (a) **Burial Anatomical Board** (b) Date thereof **7-26-45**
(Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director **[Signature]**
(b) Address **3500 [Address]**

19. (a) **JUL 30 1945** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **16,**
year **1945** hour **3** minute **41** A.M.

21. I hereby certify that I attended the deceased from **July 10,** 19**45** to **July 16,** 19**45**
that I last saw him alive on **July 16,** 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis** Duration **UNK.**

Due to _____

Due to _____

Other conditions **13 1/2**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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 **B. F. Mump...** (M. D. or other) **0**
Address **2601 N. Whittier** Date signed **7/19/45**

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.....

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. aug
Registrar's No. 6670

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME William Mosley

3. (b) If veteran, name war..... 3. (c) Social Security No. 1

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced 5

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

7. Birth date of deceased Mar (Month) 4 (Day) 1905 (Year)

8. AGE: Years 55 Months 5 Days 5 If less than one day..... hr. min.

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

10. Usual occupation laborer

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) AUG 20 1945 (Date received local registrar) J. F. Bresick (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug year 1945 hour 10 minute 15 M.

21. I hereby certify that I attended the deceased from..... to....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions..... (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..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

1945
S-22343
