

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

No. 300
10.48

FILED JUL 26 1951

State File No. **25042**
Registrar's No. **5702**

BIRTH NO. **48557-51-** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY St Louis			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS MO		c. LENGTH OF STAY (in this place) 7 HOURS	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS Le May,		d. STREET ADDRESS (If rural, give location) 486, 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION: INCARNATE WORD Hosp						
3. NAME OF DECEASED a. (First) MICHAEL b. (Middle) GLEN c. (Last) MOSS			4. DATE OF DEATH (Month) (Day) (Year) JUNE 24 1951			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH JUNE 24 1951	9. AGE (In years last birthday) 7	IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ST LOUIS MO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME WARREN MOSS		13b. MOTHER'S MAIDEN NAME RACHEL MERCILLE		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME WARREN MOSS LEMAY MO ADDRESS			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity - 6 mos ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cause unknown DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 776X			
22. I hereby certify that I attended the deceased from 24 June, 1951 , to 24 June, 1951 , that I last saw the deceased alive on 24 June, 1951 , and that death occurred at 10 P m., from the causes and on the date stated above.						
23a. SIGNATURE A. Dworkin M.D. (Degree or title)			23b. ADDRESS 1657 So Grand		23c. DATE SIGNED 25 June 51	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JUNE 25 1951	24c. NAME OF CEMETERY OR CREMATORY ANTONIA CEMETERY		24d. LOCATION (City, town, or county) (State) ANTONIA MO		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUN 25 1951 J. B. Karsta		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HEILIGTAG FUNERAL HOME				

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Elmer Heiligtag*.....

Licensed Embalmer No. *3571*.....

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.