

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21005**
Registrar's No. **5644**

BIRTH NO. **39623-54** 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 Missouri b. COUNTY 2119	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis 0 township)		c. LENGTH OF STAY (in this place) 1hr. 7mins	
c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 0		d. STREET ADDRESS (If rural, give location) 2512 N. Vandeventer	
d. FULL NAME OF HOSPITAL OR INSTITUTION Comer G. Phillips			
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) Mosley		b. (Middle)	
c. (Last)		6 8 54	
5. SEX Fem. 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0	8. DATE OF BIRTH 6-8-54
9. AGE (In years last birthday)	10. MONTHS	11. DAYS	12. HOURS MIN.
			1 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		Missouri	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Missouri			
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	
		Callie Mosley	
14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME		ADDRESS	
<i>Walter M. Sherrard</i>		2601 N. Whittier	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atelectasis		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.			
II. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to the death but not related to the disease or condition causing 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)		762.0	
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?			
22. I hereby certify that I attended the deceased from 6-8-1954 , to 6-8-1954 , that I last saw the deceased alive on 6-8-1954 , and that death occurred at 7:15a m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title)		23b. ADDRESS	
<i>William H. Siskler</i> M. D.		2601 N. Whittier	
23c. DATE SIGNED		6-9-54	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE	
		6-30-54	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
Anatomical Board		St. Louis, Mo.	
DATE REC'D BY LOCAL REG. JUN 24 1954		REGISTRAR'S SIGNATURE <i>J. Paul Smith</i>	
		25. FUNERAL DIRECTOR'S SIGNATURE Rowland-Aker Mortuary Service ADDRESS 2112 Manchester Ave. St. Louis 10, Mo.	

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.....

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.