

Health, Welfare, Public Service

FILED JUL 22 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **26969**
Registrar's No. **1676**

Registration District No. **317** Primary Registration District No. **690**

300
1-56

Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
O.D. Deebaugh, M.D. 105 W. Lockwood Ave.

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| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Valley Park Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN Affton 4790 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Moll Nursing Home 5 yrs. Length of stay in b. | | d. STREET ADDRESS 8673 Gen. Grant Lane (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Winifred Middle E. Last Mosby | | | 4. DATE OF DEATH July 3, 1957 Month July Day 3 Year 1957 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 10, 1884 |
| 9. AGE (In years last birthday) 72 | | IF UNDER 1 YEAR Months 72 Days 0 Hours 0 Min. 0 | IF UNDER 24 HRS. Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and state or country) Illford, Essex, England |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Unknown | |
| 14. MOTHER'S MAIDEN NAME Unknown | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Sam. J. Mosby 8673 Gen. Grant Lane Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hypertensive cardiovascular disease DUE TO (c) Vascular arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour 5:45 Month Mar Day 1953 Year 1953 a. m. A.M. p. m. | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20f. CITY, TOWN, OR LOCATION St. Louis | COUNTY St. Louis | STATE Mo. |
| 21. I attended the deceased from Mar 1953 to July 3 1957 and last saw her alive on July 1 1957 Death occurred at 5:45 A.M. m on the date stated above; and to the best of my knowledge from the causes stated. | | | 22. DATE SIGNED 7/3/57 |
| 22a. SIGNATURE (Degree or title) O.D. Deebaugh M.D. | | 22b. ADDRESS Webster Groves Mo | 22c. DATE SIGNED 7/3/57 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 23b. DATE 7-3-57 | 23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory | 23d. LOCATION (City, town, or county) (State) St. Louis County, Mo. |
| 24. FUNERAL DIRECTOR Mittelberg Funeral Home ADDRESS Webster Groves, Mo. | | 25. DATE RECD. BY LOCAL REG. 7/3/57 | 26. REGISTRAR'S SIGNATURE Herbert B. Dombrowski |

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
Signature of Student Embalmer

Signed *John J. Haines*

Licensed Embalmer No. *41*

P. O. Address *St Paul*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.