

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

950-61-015979
STATE FILE NUMBER

AMENDED Registration District No. 317 Primary Registration District No. 500 Registrar's No. 950

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

FILE

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Robertson Length of stay in lb. YRS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1845 Fee Fee Rd. Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN ROBERTSON Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 4845 FEE FEE RD Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year
MOSES G MOSBY April 1st 1961

5. SEX Male 6. COLOR OR RACE Col 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 6-27-1879 9. AGE (last birthday) 81 IF UNDER 1 YEAR Months 9 Days 4 IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter 10b. KIND OF BUSINESS OR INDUSTRY Bank 11. BIRTHPLACE (City and state or country) St. Louis, Missouri 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME John Mosby 13b. MOTHER'S MAIDEN NAME Anna Walder 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) yes 4-17-08 4-16-1911 17. INFORMANT CARTER'S NURS HOME 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) Congestive Heart Failure INTERVAL BETWEEN ONSET AND DEATH 3 mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____

20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Jan. 1 1961 to March 31, 1961 and last saw her alive on March 24 1961
Death occurred at 4845 Fee Fee Rd m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. W. Robinson M.D. 22b. ADDRESS 5781 Carson Rd St Louis 40 22c. DATE SIGNED 4/5/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 23b. DATE 4-10-1961 23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery 23d. LOCATION (City, town, or county) (State) St. Louis Co Mo

24. FUNERAL DIRECTOR ADDRESS JAS H. RANDLE & SON 3133 Bell Ave 25. DATE RECD. BY LOCAL REG. 4-7-61 26. REGISTRAR'S SIGNATURE J. B. Murphy M.D.

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

Ether N. Harris

Licensed Embalmer No. *4158*

P. O. Address *418 1/2 Wacker*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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