

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-004256

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318 Primary Registration District No. 1003 Registrar's No. 901

STATE FILE NUMBER

AMENDED

Registration District No. 318
 FILED JAN 25 1962

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dent			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			Length of stay in 1b		c. CITY OR TOWN Salem		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) No. Henderson	
3. NAME OF DECEASED (Type or print) First Middle Last Lillie Moser				4. DATE OF DEATH Month Day Year January 17, 1962			
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 10/27/1883	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Birch Tree, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME Lucian Jadwin			13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE John Elva Moser		
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 Mrs. Clinton Schattgen, 10088 Litzinger Rd. 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) <i>Cystoadenocarcinoma of prostate</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>metastases to colon & pelvis</i> DUE TO (c) <i>& Peritonium</i>							INTERVAL BETWEEN ONSET AND DEATH 5 mos
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. 175-0 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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 a.m. p.m.		Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <i>Sept 1961</i> to <i>Jan 62</i> and last saw her/him alive on <i>18 Jan 62</i> Death occurred at <i>11 AM 1/17/62</i> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>ARDactor MD</i>				22b. ADDRESS <i>453 N Taylor</i>		22c. DATE SIGNED <i>1/19/62</i>	
23a. FUNERAL CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-20-62		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) New Hope, Mo. (State)	
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.				25. DATE RECD. BY LOCAL REG. JAN 20 1962		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

FEB 1 1962

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 *J. W. Embler*
Licensed Embalmer No. 5653

P. O. Address *M. L. Smith*

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.