APR 27 1927

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

9425

1. PLACE OF DEATH
County St. Louis Registration District No. 784
Township St. Ferdinand Primary Registration District No. 6030
City Florissant Mo. (No. Florissant Mo. St. Ward)

File No.
Registered No.

2. FULL NAME Elenora Moeller
(a) Residence. No. Florissant Mo. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 11-1867

7. AGE: Years 60 | Months 1 | Days 20 | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

PARENTS
10. NAME OF FATHER John Moeller
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Mary Stutte
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Elizabeth Moeller
(Address) Florissant Mo.

15. FILED 3-4 1927 O. Schuster REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 3, 1927

17. I HEREBY CERTIFY That I attended deceased from Aug 1 1926 to Mar. 3, 1927 that I last saw her alive on Mar 2, 1927, and that death occurred, on the date stated above, at 5.15 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Arthritis
Deformans
59A
(duration) 28 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 52 N
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. J. Williams, M. D.
3-3, 1927 (Address) Florissant Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mt. Olive Cem. | DATE OF BURIAL: Mar. 5, 1927.

20. UNDERTAKER: Jos. W. Clark | ADDRESS 1125 Hodiamont Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.