

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

Do not use this space.

12830

1. PLACE OF DEATH

County St. Louis
Township Central
City St. Louis

Registration District No. 789
Primary Registration District No. 6030B
(No. 8751 North Ave.)

File No. _____
Registered No. 105
St. _____ Ward _____

2. FULL NAME

Henry C. Moller

(a) Residence. No. 8751 North 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 18 1873

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>53</u>	<u>11</u>	<u>17</u>	<u>18</u>

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer St. Louis City

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Iowa

10. NAME OF FATHER

Christ Moller

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Unknown

14.

INFORMANT Anna M. Moller
(Address) 8751 North

15.

FILED 4 19 27 John B. Bennett REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/5 1927

17. I HEREBY CERTIFY That I attended deceased from Jan 20, 1926, to Apr 5, 1927 that I last saw h.i.l.y. alive on day 3.26.27, 1927, and that death occurred, on the date stated above, at 3.26.27 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

9003 (duration) 1 yrs. 4 mos. — da.

CONTRIBUTORY Cardio-nephritis (SECONDARY) 9512 (duration) 3 yrs. — mos. — da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam

(Signed) E. E. Whelan M. D.

4/6, 1927 (Address) 2901 Big Bend Rd.

*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

Oak Grove

DATE OF BURIAL

4/8 1927

20. UNDERTAKER

Allen Kelly

ADDRESS

4524 Easton

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.

Dr. E. G. Whelan

