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

Do not use this space.
6864

1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 1003

City St. Louis Mo. (No. 3624 a Penrose St., ... St. ..... Ward)

File No.....
Registered No. 1823

2. FULL NAME Jack Theadore Moeller.

(a) Residence. No. 5416 Emerson Ave. St., 7 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: Male.

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) 12/31/22

7. AGE: Years 5 | Months 1 | Days 17 | If less than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) St, Louis Mo.

PARENTS

10. NAME OF FATHER Oliver H. Moeller.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) St, Louis Mo.

12. MAIDEN NAME OF MOTHER Theadosia Volm.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) St, Louis Mo.

14. INFORMANT Oliver H. Moeller
(Address) 5416 Emerson Ave

15. FILED FEB 20 1928, 19 Ray C. Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/18/28 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 10-30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Simple
Meningitis
7 days
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Diabetes
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) R. Witt, M. D.
2/21, 19 28 (Address) Crowne

*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 Memorial Park Cem.
DATE OF BURIAL 2-20- 1928

20. UNDERTAKER Provost Und. Co
ADDRESS 3710 N Grand.

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.