

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

Do not use this space.

18832

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No. **5220**
 City *St. Louis* (No. *4849* *5* *Natural Bridge* St. (Ward)

2. FULL NAME

Richard E. Mollencott
 (a) Residence. No. 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 *single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Jan 17 1909*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
19 3 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Cable Splicer*
 (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) *Mo*

10. NAME OF FATHER *Guido R Mollencott*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

12. MAIDEN NAME OF MOTHER *Josephine Semmons*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Dont Know*

14. INFORMANT *R. E. Mollencott*
 (Address) *4849 5th Natural Bridge*

15. FILED *MAY 12 1928*
Ray C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *5-11-28* 19

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... *9:30 P.* ..

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gunshot wound
184 of head
 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) *Accident*
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
 WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) *John Dever* M.D.
5/11/28 (Address) *Dep. Coroner*

*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 *Colony* DATE OF BURIAL *May 14 1928*

20. UNDERTAKER *Arthur J. Romally* ADDRESS *2039 Main St*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

