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

Do not use this space.

791

22604

1. PLACE OF DEATH

County ..... Registration District No. 1003 ..... File No. 6633

Township ..... Primary Registration District No. ..... Registered No. .....

City St Louis (No. St Luke's Hospital St. Ward)

2. FULL NAME Joseph B Moeller

(a) Residence. No. 1024 Terman St. 18 Ward. St. Louis Co, Mo

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 17 1903

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	1	12	

8. OCCUPATION OF DECEASED 208M
(a) Trade, profession, or particular kind of work Truck Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

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

PARENTS

10. NAME OF FATHER Anton Moeller
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Gertrude Bado
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

14. INFORMANT Clara Moeller
(Address) 1024 Orma

15. FILED JUN 30 1928 Mary C. Tarlton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 29 1928

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 11:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock & Injuries
Fractured Skull
Struck by Car & Auto Collision
St. Louis, Mo. (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Contusions Cerebrum
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED 185 C
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Wm Dwyer M.D.
6/30, 1928 (Address) 814 Commerce

*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	DATE OF BURIAL
Valhalla	July 2 1928
20. UNDERTAKER	ADDRESS 4475
Sanger & Shrader	Washington

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.