

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

Do not use this space.

30855

3879

399

1. PLACE OF DEATH

County Jackson Registration District No. 1002 File No. _____
 Township Kaw Primary Registration District No. _____ Registered No. _____
 City Kansas City (No. St. Luke's Hospital) St. _____ Ward _____

2. FULL NAME August Moellendick

(a) Residence. No. 501 West 11th St. St. 1 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 14, 1894

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>35</u>	<u>5</u>	<u>27</u>		

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Manager Weyl-Zuckerman
 (b) General nature of industry, business, or establishment in which employed (or employer) Produce Co.
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Germany

10. NAME OF FATHER Peter Moellendick

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Margaret Huether

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Germany

14. INFORMANT Frances Moellendick (Address) 501 West 11th St

15. FILED 9/14, 1929 M. M. Crowe REGISTRAR
asst.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 11, 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 Sept 11, 1929, to Sept 11, 1929, that I last saw h. Sept 11, 1929, and that death occurred, on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Brain abscess (cerebellar) with respiratory collapse

CONTRIBUTORY (SECONDARY) Chronic appendicitis
20 years (duration) 20 yrs. yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Don't know

IF NOT AT PLACE OF DEATH

1. DID AN OPERATION PRECEDE DEATH? yes DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) Quon Depon, M. D. 9/12, 1929 (Address) K 6 mo

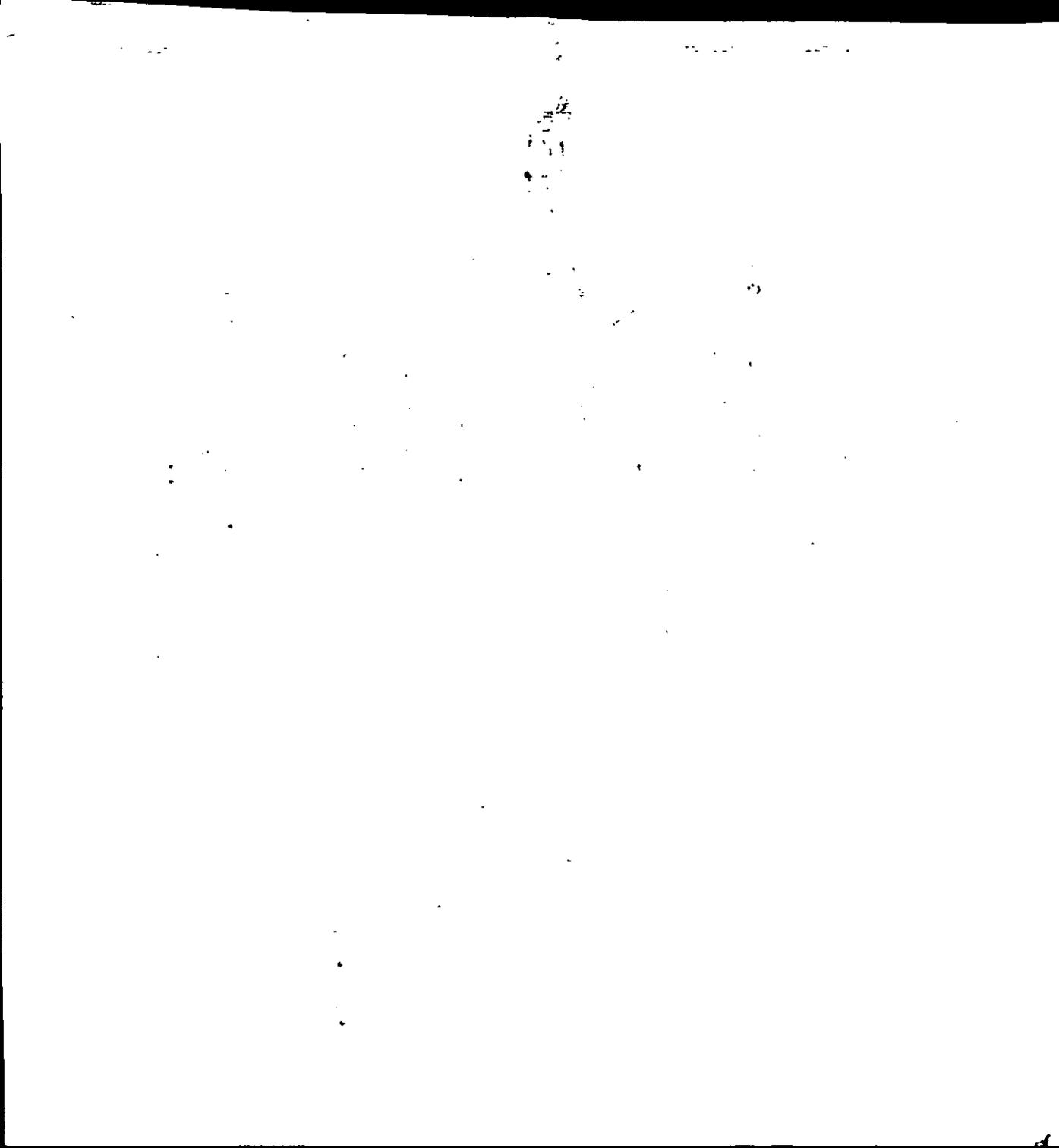
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Elmwood Crematory DATE OF BURIAL 9-14, 1929

20. UNDERTAKER Stue & McClure ADDRESS 2235 Billham Pl

107157

PARENTS



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Kaw Primary Registration District No. 1002 Registered No. 3879
 City K. C. Mo (No. St Luke's Hospital) St. _____ Ward _____

2. FULL NAME August Maellendick

(a) Residence. No. 501 W. 11th St 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 _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) _____ yrs. _____ mos. _____ ds.
 (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) _____

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT _____ (Address) _____

15. FILED 9/14, 1929 m.m. Coyne REGISTRAR
Asst.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 11th 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (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? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.
 _____, 19____ (Address) _____

*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 Ashes Buried in Forest Hill DATE OF BURIAL 10/14 1929

20. UNDERTAKER Hing + Mc Cleure ADDRESS K. C. Mo

SUPPLEMENTARY

REGISTRARS SIGNATURES INDICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED LAW

S-36855