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

Do not use this space.

2937

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 2937

Township ..... Primary Registration District No. 1003 Registered No. 73

City St. Louis (No. 4265 Holly Ave. St. ..... Ward)

2. FULL NAME Virginia E. Moeller

(a) Residence. No. 4265 Holly St., 10 Ward. (If nonresident give city or town and State)
(Usual place of abode)

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: Female
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) Aug-10-1926

7. AGE: 4 YEARS, MONTHS: 4, DAYS: 22 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(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) St. Louis

PARENTS

10. NAME OF FATHER Wm. C. Moeller
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) St. Louis Mo
12. MAIDEN NAME OF MOTHER Emma Dirks
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) St. Louis Mo

14. INFORMANT Mr Wm. C. Moeller
(Address) 4265 Holly Ave

15. FILED JAN -3 1931, 19 Max C Starker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 2 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 27, 1930, to Jan 1st, 1930, that I last saw her alive on Jan 1, 1930, and that death occurred, on the date stated above, at 4 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia Primary

..... (duration) ..... yrs. ..... mos. ..... ds.

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) Louis N Thom, M. D
, 19 (Address) 3800 Olive

*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: Bethany. DATE OF BURIAL: Jan 5 1931

20. UNDERTAKER: Hy Leidner Und Co. ADDRESS 1407 N. Market St

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.