

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.

OCT 14 1937

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

32788

Do not use this space.

1. PLACE OF DEATH

(a) County.....
(b) Township.....
(c) City St. Louis, Mo. (d) Street No. 29123 Indiana St. Ind.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

Registration District No. 1003

Primary Registration District No. 1003

Registered No. 8842

2. PRINT FULL NAME

Catherine Moebes
(a) Residence, No. 29129 Indiana St. Ind.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 George Moebes
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 9 1864
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 2 12
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House wife
9. Industry or business in which work was done, as saw mill, bank, etc. Home
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

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

13. NAME Michael Delaney
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

15. MAIDEN NAME UNKNOWN
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT (ADDRESS) Geo Moebes
29123 Indiana

18. BURIAL, CREMATION, OR REMOVAL PLACE Cemetery DATE Sept 24 37

19. FUNERAL DIRECTOR (ADDRESS) WITT Bros. L & Co.
2929 So. Jefferson Ave

20. FILE NO. 221957 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 21, 1937

22. I HEREBY CERTIFY That I attended deceased from Sept 3, 1937 to Sept 21, 1937
I last saw her alive on Sept 21, 1937 Death is said to have occurred on the date stated above, at 11:20 a.m.
The principal cause of death and related causes of importance were as follows:

Myocarditis - chronic
Diabetes Mellitus
Arteriosclerosis - generalized
Date of onset ?

Name of operation..... Date of.....
What test confirmed diagnosis Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify Pierce W. Powers M. D.
(Signed) 2531 So. Jefferson
(Address)

STATEMENT BY LICENSED EMBALMER

I, Paul G. Shanklin, Licensed Embalmer No. 3472

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Paul G. Shanklin

..... L. E.

No. 3472 or by

working under my personal supervision.

Signed Paul G. Shanklin Registered Apprentice No.

Licensed Embalmer No. 3472

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)