

REC'D APR 12 1939

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

9294
Do not use this space.

1. PLACE OF DEATH

(a) County..... 1 Registration District No..... 1008
(b) Township..... Primary Registration District No.....
(c) City *St. Louis MO* (d) Street No. *St. Anthony Hospital* St.
(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.

2. PRINT FULL NAME

400 Infant Moll
(a) Residence, No. *2710 2 accorac St* St. *23* (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *March 30 - 1939*
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
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 *Theodore Moll*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis MO*

15. MAIDEN NAME *Agnes Ballmann*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Krakow Mo*

17. INFORMANT (ADDRESS) *Theodore Moll 2710 2 accorac St*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Calvary* DATE *March 31 39*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *H. Heckenroth & Co. 2630 Levee Ave*

20. FILED *J. B. Budick* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *March 30 - 1939*
I HEREBY CERTIFY, That I attended deceased from *March 30, 1939, to March 30, 1939*
I last saw him alive on *March 30, 1939*. Death is said to have occurred on the date stated above, at *1303*
The principal cause of death and related causes of importance were as follows:

Stellborn
Other contributory causes of importance:
food withheld and by causing circulatory obstruction

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

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?.....
If so, specify.....
(Signed) *Theodore Moll*, M. D.
(Address) *3600 Olive 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.

1 X18605

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Herman A. Gebken

Licensed Embalmer No. 2120

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.