

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26829
Registrar's No. 1348

Registration District No. 1835

Primary Registration District No. 200

1. PLACE OF DEATH: 2
(a) County St. Louis
(b) City or town Overland
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 38 YEARS (Specify whether years, months or days)

3. (a) PRINT FULL NAME Di Ettrich MoehlmANN 455
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex MALE 5. Color or race White
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife Annie MoehlmANN 6. (c) Age of husband or wife if alive 85 years
7. Birth date of deceased MARCH 13 1854 (Month) (Day) (Year)

8. AGE: Years 85 Months 4 Days 13 If less than one day hr. _____ min. _____

9. Birthplace Germany (City, town, or county) (State or foreign country)

10. Usual occupation LIGHT MAKER

11. Industry or business OWN

MOTHER FATHER { 12. Name UNKNOWN
13. Birthplace Germany (City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Emma Brunst

(b) Address 8428 Lackland Rd, Overland

17. (a) Cremation (b) Date thereof July 28 1939 (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director Wm Bro. L. W.C.

(b) Address 2809 S. Jefferson Ave

19. (a) JUL 26 1939 (b) J.R. MURPHY (Date of death) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Overland (If outside city or town limits, write "RURAL")
(d) Street No. 8428 Lackland Ave (If rural, give location)
(e) If foreign born, how long in U. S. A. 50 YEARS years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26 year 1939 hour 2:00 minute _____ M.

21. I hereby certify that I attended the deceased from July 1st, 1938, to July 26th, 1939; that I last saw him alive on July 25th, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Due to Atherosclerosis

Duration
1 yr.
1 yr.

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 930

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature H. J. Schmitz M.D. (M. D. or other)
Address Pattonville, Mo. Date signed 7-27-39

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

Paul Shanklin

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Edgar F. Witt

Licensed Embalmer No. *2117*

P. O. Address *2929 S Jefferson*

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

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

26829
Do not use this space.

1. PLACE OF DEATH
 (a) County St. Louis Registration District No. 784
 (b) Township Overland Primary Registration District No. 200 Registered No. 1348
 (c) City..... (d) Street No..... St.
 (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.
 (If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME Dietrich Moehlmann
 (a) Residence, No. St. (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED M (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.
85 4 13

OCCUPATION

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)

FATHER

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

MOTHER

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 7-26 1939 T.R. Meyer, M.D., P.H.C. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-26, 1939

22. I HEREBY CERTIFY, That I attended deceased from to, 19.....
 I last saw h..... alive on, 19..... Death is said to have occurred on the date stated above, at..... m.
 The principal cause of death and related causes of importance were as follows:
 Date of onset

Other contributory causes of importance:

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) H. J. Colman, M. D.
 (Address) St. Louis

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-26829