

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Registration District No. 784

Primary Registration District No. 104

Registrar's No. 1983

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Ferguson
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Pollock's Nursing Home 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Years
(Specify whether

In this community years, months or days)

3. (a) PRINT FULL NAME Nancy R. Moller 460

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Late Charles Moller

6. (c) Age of husband or wife if alive years

7. Birth date of deceased July 20th 1872
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>3</u>	<u>22</u>	<u>hr.</u> <u>min.</u>

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

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER { 12. Name Samuel Dunn

13. Birthplace Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Phoebe Jane Mayfield

15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Estella Smith

(b) Address 7807 Carondelet Ave.

17. (a) Burial (b) Date thereof 11-13-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Kriegshauser Mortuary

(b) Address 4228 So. Kingshighway

19. (a) NOV 11 1939 (b) G. R. Meyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Ferguson
(If outside city or town limits, write "RURAL")

(d) Street No. Pollock's Nursing Home
(If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 11th
year 1939 hour 4:45 minute A.M. M.

21. I hereby certify that I attended the deceased from June 1938
_____, 19____, to Nov 11, 1939
that I last saw her alive on Nov 11, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Terminal Bacterial Pneumonia 2 days

Due to amyotrophic lateral sclerosis 4 yrs.

Due to _____

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

PHYSICIAN _____

Major findings: Of operations none

Of autopsy none

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) no

(b) Date of occurrence no

(c) Where did injury occur? no
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

23. Signature M. Stachle (M. D. or other) no
Address 2000 E Grand Date signed 11-11-39

Natural Bridge Rd.

9505 Flammiausk

mm 3985

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.....

Edmund A. Stekler

Licensed Embalmer No. 3024

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.