

JAN 12 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

41772

Registrar's No.

10895

Registration District No.

Primary Registration District No.

## 1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
St. Anthony Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution one week  
(Specify whether  
In this community St. Louis  
years, months or days)

8. (a) PRINT FULL NAME Lottie Moeller 466

8. (b) If veteran, name war \_\_\_\_\_

8. (c) Social Security No. \_\_\_\_\_

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife Henry

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Nov. 7 1872  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

67	1	14	hr. _____ min.
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9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

12. Name John Hail

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

14. Maiden name not known

15. Birthplace not known  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Geo. A. Hanzpeler

(b) Address 3909 Bates

17. (a) Buried (b) Date thereof Dec. 23, 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial

18. (a) Signature of funeral director John H. Ziegenhain

(b) Address 7027 Gravois Ave.

19. (a) DEC 21 1939  
(Date received local registrar)

(b) Registrar's signature J. B. Buder

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis 15  
(If outside city or town limits, write "RURAL")

(d) Street No. 4449 Gravois Ave.  
(If rural, give location)

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

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 21  
year 1939 hour 1 minute 15 A. M.

21. I hereby certify that I attended the deceased from Dec 21, 1939, to Dec. 21, 1939;  
that I last saw her alive on Dec 20, 1939;  
and that death occurred on the date and hour stated above.

Immediate cause of death Concussions of brain with generalized metastasis

Duration

4 mos.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Chronic Rheumatoid Arthritis  
(Include pregnancy within 3 months of death)  
syndrome - arthralgia fibrillation

Several years.

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: no

(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 Wm. J. Wotawa MD (M. D. or other)

Address 3804 Wilmingtn Date signed 12/21/39

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**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 C. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 6937<sup>a</sup> Grauss

**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.**