APR 15 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8986

Registration District No. 791 1

Primary Registration District No. 1003

Registrar's No. 2469

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: 5409a Gravois Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis 2
(If outside city or town limits, write "RURAL")

(d) Street No. 5409a Gravois Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME Louis J. Motz

3. (b) If veteran, name war ----

3. (c) Social Security No. ----

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Irene Motz

6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased May (Month) 7, (Day) 1881 (Year)

8. AGE: Years 58 Months 10 Days 5 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Photographer

11. Industry or business

MOTHER FATHER

12. Name Peter Motz

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

14. Maiden name Unknown

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

16. (a) Informant's own signature Irene Motz

(b) Address 5409a Gravois Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/40 (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Wacker-Helderle

(b) Address 2331 S. Broadway

19. (a) MAR 14 1940 (Date received local registrar) (b) J. B. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

No attending physician

20. DATE OF DEATH: Month Mar. day 12 year 1940 hour 6 minute 56 p.m.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage, due to gun-shot wound of left chest, self inflicted, in garage in rear of 5407 Gravois Av., March 12,1940, about 6:56 P.M. SUICIDE.

Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN — 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) SUICIDE

(b) Date of occurrence 3/12/1940

(c) Where did injury occur? St. Louis, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? (e) Means of injury

23. Signature Joseph M. Queen (M. D. or other)

Address Deputy Coroner Date signed

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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.

U. S. 2.
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Rev. 5-17-39
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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 Robert C Wheeler

Licensed Embalmer No. 2128

P. O. Address [illegible]

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.