

2
4
3
 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. 757

Primary Registration District No. 3036

Registrar's No. 81

1. PLACE OF DEATH:
 (a) County St Charles
 (b) City or town St Charles
 (c) Name of hospital or institution: St Josephs Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 days
 (Specify whether _____)
 In this community _____
 years, months or days

8. (a) PRINT FULL NAME ALVINA MOEHLLENKAMP
 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 Single
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 1921 1883
 (Month) (Day) (Year)

8. AGE: Years 56 Months 11 Days 23
 If less than one day _____ hr. _____ min.

9. Birthplace St Charles Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____
 12. Name John Moehlencamp
 13. Birthplace St Charles Mo
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary Schueler
 15. Birthplace St Charles Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Samuel F. Oriole
 (b) Address 5827 Payne St. St. Louis Mo

17. (a) Burial (b) Date thereof May 14, 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lutheran Cemetery

18. (a) Signature of funeral director Wesleyman - Adams
 (b) Address 326 N 67th St - St Charles Mo

19. (a) 7/13/40 (b) Blarence B. Thiesler
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St Charles
 (c) City or town St Charles
 (If outside city or town limits, write "RURAL")
 (d) Street No. 416 Township St
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 12th
 year 1940 hour 3 minute 40 A.M.

21. I hereby certify that I attended the deceased from Feb
 _____, 1940, to May 12, 1940
 that I last saw her alive on May 12, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death
Mesenteric thrombosis
Gangrene small intestine 24 hr.
 Due to Emboli in mesenteric
artery branch.
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: Ch. Cholecystitis
Fibronosoma uterus
 Of autopsy Mesenteric thrombosis
Gangrene small intestine

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?
170 (Specify type of place) _____
670 While at work? (e) Means of injury _____
 23. Signature Vincent A. Schueler (M. D. or other) _____
 Address St Charles - Mo Date signed 5/13/40

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 Arthur C. Paul

Licensed Embalmer No. 3144

P. O. Address St Charles Mo

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.