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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 10 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3496

Registration District No. 754 Primary Registration District No. 200 Registrar's No. 246

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Miller Nursing Home 4
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS 96

(c) City or town AFTON 0
(If outside city or town limits, write "RURAL")

(d) Street No. 8141 GRAVOIS AVE
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Rosa Moenninghoff

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex FEMALE

5. Color or race WHITE

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

6. (b) Name of husband or wife Chas MOCKNINGHOFF

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

7. Birth date of deceased MAY (Month) 12 (Day) 1861 (Year)

8. AGE: Years 81 Months 9 Days 14 If less than one day ..... hr. ..... min.

9. Birthplace ST LOUIS (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation NIL

11. Industry or business

FATHER
12. Name CHAS. BLIND
13. Birthplace (City, town, or county) GERMANY 4 (State or foreign country)

MOTHER
14. Maiden name DONT KNOW
15. Birthplace (City, town, or county) GERMANY 4 (State or foreign country)

16. (a) Informant CHARLES BLIND
(b) Address 6446 GRAVOIS AVE

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB 1 (Month) (Day) 43 (Year)
(c) Place: burial or cremation ST. Paul Church Yard

18. (a) Signature of funeral director Weiel Bros
(b) Address 2201 S. Grand Bl.

19. (a) FEB 2 1943 (Date received local registrar) (b) C. G. McGowan MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 29 day 29th year 1943 hour 8 o'clock minute 55 M.

21. I hereby certify that I attended the deceased from January 1941, 1941, to January 29, 1943; that I last saw her alive on Jan 25th, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Exhaustion from Bronchial Asthma

Due to Bronchial Asthma with general weakness

Due to Bronchitis

Other conditions
(Include pregnancy within 3 months of death)

Major findings: Of operations Non

Of autopsy No

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

112

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature J. J. Meredith (M. D. or other) MD

Address 1059 N. Kingshighway Date signed 1-29-43

(Licensed Embalmer's Statement on Reverse Side)

Dr. Meredith

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.....

Licensed Embalmer No.....

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, fact should be so stated above.