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No. 2
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X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 27 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 730

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 332

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County 17 1
(c) City or town City 9 15
(If outside city or town limits, write "RURAL")
(d) Street No. 5118 Wicklow Pl.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Paul August Moehle

3. (b) If veteran, name war
3. (c) Social Security No. None

4. Sex Male
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 April (Month) 11 (Day) 1920 (Year)

8. AGE: Years 23 Months 8 Days ~~19~~ 28 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country) 0
10. Usual occupation Home
11. Industry or business

FATHER
12. Name August Moehle
13. Birthplace St. Louis (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name Martha Wilder
15. Birthplace Chicago, Ill. (City, town, or county) 1 (State or foreign country)

16. (a) Informant August Moehle
(b) Address 5118 Wicklow Pl.
17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof Jan 12, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Crem.
18. (a) Signature of funeral director Hacker-Helderle since Hacker-Helderle
(b) Address 3634 Gravois
19. (a) JAN 12 1944 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 9
year 1944 hour 9:00 minute P M.

21. I hereby certify that I attended the deceased from January 4, 1944, to January 9, 1944
that I last saw him alive on January 9, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Post-traumatic Epilepsy ~~paralysis~~ Paralysis
Due to At the age of eleven years, deceased
Due to was injured by a fall. Epilepsy developed and lower limbs
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations were paralyzed
Of autopsy 193 [illegible]

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 000
(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 [signature] (M. D. or other)
Address 1515 Lafayette Avenue Date signed 1/10/44

(Licensed Embalmer's Statement on Reverse Side)

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. 2178

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.