

S. No. 2
 MOM-2-43
 v. 5-17-39
 I X35697

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **5507**
 Registrar's No. **1382**

FILED FEB 18 1944
 818
 Registration District No.

Primary Registration District No. **1003**

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

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:
5530 Genevieve Ave.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community **Unknown**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **17**
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **5530 Genevieve Ave.**
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country **0**

3. (a) PRINT FULL NAME **August R. Moeller**
 3. (b) If veteran, name war **No**
 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **February** day **10th**
 year **1944** hour **11:05** minute **P.** M.

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Katherine Moeller**
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **May 5, 1881.**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Nov 1943** 19 _____ to **Feb 10, 1944**
 that I last saw him alive on **Feb 10, 1944**
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____
 Duration _____

8. AGE: Years Months Days If less than one day
62 **9** **5** hr. min.
 9. Birthplace **Ellis Grove, Illinois.**
(City, town, or county) (State or foreign country)

Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations _____
 Of autopsy _____

10. Usual occupation **Grocer**
 11. Industry or business _____
 12. Name **Frederick Moeller**
 13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
 14. Maiden name **Wilhelmina Abelmann**
 15. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Mrs. Katherine Moeller**
 (b) Address **5530 Genevieve Ave.**
 17. (a) **Burial** (b) Date thereof **Feb. 14, 1944.**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Memorial Park Cemetery**

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? _____

18. (a) Signature of funeral director **CALVIN F. FEUTZ FUNERAL HOME**
 (b) Address **4828 Natural Bridge Blvd.**
 19. (a) **FEB 12 1944** (b) **J. F. Brebeck**
(Date received local registrar) (Registrar's signature)

23. Signature _____ (M. P. of other) _____
 Address **5704 W. Belmont** Date signed **Feb 11/44**
(Specify type of place) (c) Means of injury

6704 N. Gloucest Ave.
11-10 AM 6-8 PM

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 John A. Miller

Licensed Embalmer No. 4186

P. O. Address St. Louis 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, fact should be so stated above.