S. No. 2
M—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 29 1945

Registration District No. 317

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3520

Primary Registration District No. 6076

Registrar's No. 2737

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Jennings Mo. (If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 1 1/2 Day (Specify whether years, months or days)

In this community 1 1/2 Day

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: 90

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

(d) Street No.: 716 Baden Ave. (If rural, give location)

(e) Citizen of foreign country? (Yes or No): 1

If yes, name country:

3. (a) PRINT FULL NAME: Mary Moeller

3. (b) If veteran, name war: none

3. (c) Social Security No.: none

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: Dec. (Month) 22 (Day) 1863 (Year)

8. AGE: Years 81 Months Days 13 If less than one day hr. min.

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

10. Usual occupation: House Work

11. Industry or business:

MOTHER FATHER

12. Name: Henry Moeller

13. Birthplace: Germany (City, town, or county) 4 (State or foreign country)

14. Maiden name: Marie Schone

15. Birthplace: Germany (City, town, or county) 4 (State or foreign country)

16. (a) Informant: Louise Moeller

(b) Address: 716 Baden Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 8 1945 (Month) (Day) (Year)

(c) Place: burial or cremation: Luth. Cem. St. Charls Mo.

18. (a) Signature of funeral director: Diedrich F. Home

(b) Address: 8319 Halls Ferry Rd.

19. (a) JAN 8 1945 (Date received by local registrar) (b) E. H. McGavran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 4 year 1945 hour 10 minute 15 P. M.

21. I hereby certify that I attended the deceased from May 8, 1943, to Jan 2, 1945, that I last saw h. alive on ..., 19..., and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hemiplegia Left	2 Days
Due to: Arterial Hypertension	1 yr
Due to: General Arteriosclerosis / Chronic nephritis	1 yr
Other conditions (Include pregnancy within 3 months of death): Coronary Sclerosis	1 yr

Major findings:
Of operations: NONE
Of autopsy: No

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):

(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. Wellering (M. D. or other)

Address: 8321 No Broadway Date signed: 1/6/45

(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 W W Elkinson

Licensed Embalmer No. 3575

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.