

S. No. 2
M-2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29827

FILED AUG 3 1945
318

Registration District No. _____ Primary Registration District No. 100 Registrar's No. 6798

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: St. Johns Hospital
(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 Mo. (b) County 000
(c) City or town St. Louis 17 6
(If outside city or town limits, write "RURAL")
(d) Street No. 4768 St. Louis Ave.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Lillie E. Mollencott
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 29
year 1945 hour 5 minute 45 A. M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Geo. R. Mollencott 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased Jan. 26 1876
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 5, 1945, to July 29, 1945
that I last saw him alive on July 25, 1945
and that death occurred on the date and hour stated above.

8. AGE: Years 69 Months 1 Days 3 If less than one day _____ hr. _____ min.

Immediate cause of death:
Myocardial Infarction 3 days
Ch. Interstitial Nephritis 4 wk
Due to... Acute Hepatitis 1 wk
Due to... Ch. Biliary Cystitis 10 yrs

9. Birthplace _____ (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation Housewife

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations 174 1
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____
12. Name Emil Thomure
13. Birthplace _____ (City, town, or county) Mo. 0 (State or foreign country)
14. Maiden name Julia Mertell
15. Birthplace _____ (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant G. R. Mollencott
(b) Address 4768 St. Louis Ave.
17. (a) Burial (b) Date thereof 8-1-45
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____
While at work? _____ (Specify type of place) (e) Means of injury 0

(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Drehmann-Harral
(b) Address 1905 Union Blvd.
19. (a) JUL 31 1945 J. P. O'Neil
(Date received local registrar) (Registrar's signature)

23. Signature _____ (M. D. or other) MD
Address 4987 Maryland Date signed 7/30/45

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

0
7
9

1 to 5

Home of Dr. Office

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..... *Warren A. Carver*

Licensed Embalmer No. *3534*

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.