S. No. 2
M—5-43
FILED SEP 1 1945

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25970

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7445

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

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: De Paul Hospital 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks (Specify whether In this community Life, years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 21

(c) City or town St. Louis, 17 (If outside city or town limits, write "RURAL")

(d) Street No. ~~18th & Pine Evangeline Home~~, 1803 Pine Street (If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Cecilia E. Moyle,

3. (b) If veteran, name war No

3. (c) Social Security No.

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 November 17, 1890 (Month) (Day) (Year)

8. AGE: Years 54 Months 9 Days 8 If less than one day hr. min.

9. Birthplace St. Louis, Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation Secretary

11. Industry or business Mercantile Commerce Bk

FATHER
12. Name Leigh Moyle,
13. Birthplace (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Mary A. Riha
15. Birthplace St. Louis, Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Randall Moyle,

(b) Address Rte 8 Lemay Mo.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/45 (Month) (Day) (Year)

(c) Place: burial or cremation Old SS Peter & Paul

18. (a) Signature of funeral director Oscar J Hoffmeister

(b) Address 4016 Chippewa,

19. (a) AUG 27 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 25 year 1945 hour 6 minute 50 P.M.

21. I hereby certify that I attended the deceased from Sept 1942, to Aug 25, 1945; that I last saw her alive on Aug 25, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Intestinal obstruction & peritonitis	4 days
Due to: Pernicious anemia	4 years
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: Intestinal obstruction due to adhesions
Of autopsy: Fresh adhesions causing intestinal obst & peritonitis

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. R. [illegible] (M. D. or other)

Address 539 N [illegible] Date signed Aug 27 45

(Licensed Embalmer's Statement on Reverse Side)

AUG 27 1945

Emb separate cert to be filed

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.