

S. No. 2  
 DM-5-42  
 v. 5-17-39  
 X32873

DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

39560

State File No. ....

FILED 1945  
 REG 21  
 318

Registration District No. .... Primary Registration District No. .... Registrar's No. 10535

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

1. PLACE OF DEATH:  
 (a) County.....  
 (b) City or town..... St. Louis, Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 1447 Hamilton 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.....  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State..... Missouri  
 (b) County.....  
 (c) City or town..... City of St. Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No..... 1447 Hamilton Ave  
 (If rural, give location)  
 (e) Citizen of foreign country?.....  
 (Yes or No)  
 If yes, name country.....

3. (a) PRINT FULL NAME Nellie Mollencott

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month..... December..... 8th,  
 year..... 1945..... hour..... 3.00..... minute..... A..... M.....

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

21. I hereby certify that I attended the deceased from  
 Nov 1945 to Dec 8 1945  
 that I last saw her alive on Nov 22 1945  
 and that death occurred on the date and hour stated above.

4. Sex Female / 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married

Duration  
 Immediate cause of death  
 Coronary occlusion, 1 hr.

6. (b) Name of husband or wife Robert Mollencott  
 6. (c) Age of husband or wife if alive 77 years  
 7. Birth date of deceased Dec. 25th, 1874  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	70	11	13	.....hr.....min.

Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

9. Birthplace..... Ireland  
 (City, town, or county) (State or foreign country)

10. Usual occupation..... Housewife

11. Industry or business..... ? Callan

12. Name..... Ireland 4

13. Birthplace..... Unknown Unknown  
 (City, town, or county) (State or foreign country)

14. Maiden name..... Ireland 13

15. Birthplace..... Ireland 13  
 (City, town, or county) (State or foreign country)

16. (a) Informant Robert Mollencott

(b) Address 1447 Hamilton Ave

17. (a) Burial (b) Date thereof Dec 11-45  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiamont Ave

19. (a) DEC 11 1945 J. F. Bredek  
 (Date received local registrar) (Registrar's signature)

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..... (M. D. or other)  
 Address 1125 Hodiamont Ave Date signed.....

Dr. E. E. Evans  
1506 Hoddiamont Ave  
Co. 7775

10795

10795

---

---

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..... *Alfred J. Boedecker* .....

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.**