No. 2
-1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 23 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 32820

Registrar's No. 8586

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: City Hosp. #1 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 4112 E. Iowa Av. 9
(If rural, give location) 15 0
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Oscar Moekel
3. (b) If veteran, name war no.
3. (c) Social Security No. no.
4. Sex Male
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 April 23 1853 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
94	4	17	hr. min.

9. Birthplace Germany (City, town, or county) (State or foreign country) 4
10. Usual occupation Retired Cook
11. Industry or business
MOTHER FATHER
12. Name Unk. Moekel 7
13. Birthplace Unk. 7
(City, town, or county) (State or foreign country)
14. Maiden name " 7
15. Birthplace " 7
(City, town, or county) (State or foreign country)
16. (a) Informant Dr. Wm Beckman
(b) Address 3604 Loughborough St.
17. (a) Cremation (b) Date thereof 9-11-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mo. Crematory
18. (a) Signature of funeral director Witt Bros & Co
(b) Address 2929 S. Jefferson Av.
19. (a) SEP 11 1947 (Date received local registrar) (b) J. F. Bielack (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 10 year 1947 hour 8 minute 15a M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Fractured Right Hip
Due to Arteriosclerosis Generalized
Due to When deceased fell & fractured hip while walking in my home 4112 E. Iowa Av. on July 26
Due to 9-9-47
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

Duration
8 mo
1
16

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

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence July 26 1947 noon
(c) Where did injury occur? 15 (City or town) (County) (State)
(d) Did injury occur in or about home, or farm, in industrial place, in public place? Home (Specify type of place)
While at work? (e) Means of injury Fall
23. Signature Alfred Perry (M. D. or other) Coroner
Address Deputy Coroner Date signed 9/11/47

Jefferson City Printing Co.

(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 Harold C. Witt

Licensed Embalmer No. 4353

P. O. Address 2929 S. Jefferson Av

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.