

No. 2  
2-45  
17-39  
5-27070

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

NOV 10 1947

FILED NOV 10 1947

Registration District No. **3874**

Primary Registration District No. **60X6**

Registrar's No. **20**

1. PLACE OF DEATH:

(a) County **St Charles**  
 (b) City or town **Rural**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**Near New Melle**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
 In this community **Life**  
(Years, months or days)

3. (a) PRINT FULL NAME **Frank Moellering**

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

4. Sex **M** 5. Color or race **W**

6. (a) Single, widowed, married, divorced **Married**  
 6. (c) Age of ~~husband~~ or wife if alive **65** years

7. Birth date of deceased **Nov, 27, 1871**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>76</b>	<b>10</b>	<b>26</b>	hr. _____ min. _____

9. Birthplace **St, Charles, Co**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business \_\_\_\_\_

12. Name **Fritz Moellering**

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

14. Maiden name **Dont Know**

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

16. (a) Informant **Nittie Moellering**

(b) Address **New Melle, Mo.**

17. (a) **Burial** (b) Date thereof **10-21-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New Melle**

18. (a) Signature of funeral director **Manier Mansberg**  
 (b) Address **Wentzville, Mo.**

19. (a) **Oct 26 47** (b) **Jennie H. Coe**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St, Charles 92**  
 (c) City or town **Rural**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. **Near New Melle, Mo.**  
(If rural, give location)  
 (e) Citizen of foreign country? **No** (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **19**  
 year **1947** hour **7** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **September 20**, 19**47** to **October 17**, 19**47**  
 that I last saw him alive on **October 17**, 19**47**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial DEGENERATION**  
 Duration **6 mo.**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy **930**

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury **2**

23. Signature **W.E. Bargesen** (M. D. or other) **D.O.**

Address **Wentzville, Mo.** Date signed **10-20-47**

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**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 *Maria Murphy*

Licensed Embalmer No. *2461*

P. O. Address *Wentzville, Mo*

**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.**

Registration District No. 304 Primary Registration District No. 6046

1. PLACE OF DEATH:  
(a) County St Charles  
(b) City or town Rural  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_  
years, months or days (Specify whether \_\_\_\_\_)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County St Charles  
(c) City or town \_\_\_\_\_  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? \_\_\_\_\_

3. (a) PRINT FULL NAME Frank Mollering  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
year 1947 hour \_\_\_\_\_ minute 30 a.m.

4. Sex M 5. Color or race W  
6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased Nov 27 1893

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

8. AGE: Years 76 Months 02 Days 02 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace St Charles Mo

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_

10. Usual occupation Seaman  
11. Industry or business \_\_\_\_\_  
12. Name Frank Mollering  
13. Birthplace Germany  
14. Maiden name Paula Mollering  
15. Birthplace Germany

Of autopsy \_\_\_\_\_  
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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

16. (a) Informant Nettie Mollering  
(b) Address New Melle Mo  
17. (a) Rural (b) Date thereof 10-21-47  
(c) Place: burial or cremation New Melle  
18. (a) Signature of funeral director Wentrille Mo  
(b) Address \_\_\_\_\_  
19. (a) Oct 26 1947 (b) Jennie Gussman

While at work? \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

**TEMPORARILY**

MOTHER FATHER

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

S-35405