

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 22905

FILED JUL 5 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 1766

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Clayton</u>		c. LENGTH OF STAY (in this place) <u>20 yrs</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>7738 Carondelet</u>		d. STREET ADDRESS (If rural, give location) <u>7738 Carondelet</u>	

3. NAME OF DECEASED a. (First) EDWARD b. (Middle) LOUIS c. (Last) MOELLER d. DATE OF DEATH (Month) (Day) (Year) 6-27-52

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 8. DATE OF BIRTH Aug 12 1885 9. AGE (In years) (last birthday) 66 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Sheet Department 10b. KIND OF BUSINESS OR INDUSTRY City of Clayton 11. BIRTHPLACE (State or foreign country) St. Louis MO 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Casper Moeller 13b. MOTHER'S MAIDEN NAME Elopheth Bentlage 14. NAME OF HUSBAND OR WIFE Maud Moeller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. none 17. INFORMANT'S SIGNATURE OR NAME Maud Moeller ADDRESS 7738 Carondelet

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Hypostatic pneumonia INTERVAL BETWEEN ONSET AND DEATH 6 days

ANTECEDENT CAUSES DUE TO (b) Crisis in liver

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (c) bronchial asthma

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION \_\_\_\_\_ 19b. MAJOR FINDINGS OF OPERATION \_\_\_\_\_ 20. AUTOPSY? YES  NO

21a. ACCIDENT (Specify) \_\_\_\_\_ 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) \_\_\_\_\_ 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 5810

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) \_\_\_\_\_ 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from death, 1952 to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on 6-26-52, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE James A. Meador (Degree or title) \_\_\_\_\_ 23b. ADDRESS 48 Central 23c. DATE SIGNED 6-28-52

24a. BURIAL, CREMATION, REMOVAL \_\_\_\_\_ 24b. DATE 6/30/52 24c. NAME OF CEMETERY OR CREMATORY Laurel Hill 24d. LOCATION (City, town, or county) (State) Wellston MO

DATE REC'D BY LOCAL REG. 6-28-52 REGISTRAR'S SIGNATURE Herbert P. Drake MD 25. FUNERAL DIRECTOR'S SIGNATURE Earl Hillman ADDRESS Oreland

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD—100

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 \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Student Embalmer No. \_\_\_\_\_

Signed *Earl L. Hillman*

Licensed Embalmer No. *35011*

P. O. Address *Orland md*

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.