.S. No. 300
REV. 10.48

FILED SEP 8 - 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29823

State File No. .....

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8155

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2847 McNair

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri
b. COUNTY 2249
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis Mo. 0
d. STREET ADDRESS (If rural, give location) 24 2847 McNair

3. NAME OF DECEASED (Type or Print)
a. (First) Arthur
b. (Middle)
c. (Last) Moehle

4. DATE OF DEATH (Month) (Day) (Year) Aug 27 1952

5. SEX Male 0
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH April 23 1899
9. AGE (In years last birthday) 53 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur
10b. KIND OF BUSINESS OR INDUSTRY Kroger Co
11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo....
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME William Moehle
13b. MOTHER'S MAIDEN NAME Christian Freiser
14. NAME OF HUSBAND OR WIFE Leona Moehle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) World War # 2
16. SOCIAL SECURITY NO. 493-03-0927
17. INFORMANT'S SIGNATURE OR NAME Leona Moehle 2847 McNair — ADDRESS

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

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Thrombosis
DUE TO (c)

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

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 4201

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 10 a.m., from the causes and on the date stated above.*

23a. SIGNATURE Joseph McQuinn Dept Town 3 (Degree or title)
23b. ADDRESS 1300 Clark
23c. DATE SIGNED 8/29/52

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 4
24b. DATE 9/22/52
24c. NAME OF CEMETERY OR CREMATORY Jeff. Barracks Cem.
24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.

DATE REC'D BY LOCAL REG. AUG 28 1952
REGISTRAR'S SIGNATURE J Carl Smith MD MDS
25. FUNERAL DIRECTOR'S SIGNATURE Wm. Schumacher — ADDRESS 3013 Meramec

(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.....

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed Jack Haupt

Licensed Embalmer No. 4346

P. O. Address St Louis

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.