

FILED OCT 3 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31247  
State File No. 8145

BIRTH NO.		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>8145</b>			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE <b>Missouri</b>				b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>1 Week</b>		c. CITY OR TOWN <b>Pinelawn</b> <i>415</i>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>St. Johns' Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>3737 Manola Ave</b>					
3. NAME OF DECEASED a. (First) (Type or Print) <b>Mary</b>			b. (Middle) <b>M.</b>		c. (Last) <b>Moeller</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>September 14, 1955</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>July 27 1882</b>		9. AGE (In years) (If under 1 year last birthday) (Months) (Days) (Hours) (Min.) <b>73</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis County Mo.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Frank F. Seitz</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Bobrink</b>			14. NAME OF HUSBAND OR WIFE <b>George D. Moeller</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, as unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>489 01 5471B</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>George Moeller 3737 Manola Ave.</b>				
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral malaria</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cerebral malaria</b> DUE TO (c) <b>hypertensive heart disease</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 Yrs.</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>170x</b>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <b>8-3-1955</b> , to <b>9-14-1955</b> , that I last saw the deceased alive on <b>9-14-1955</b> , and that death occurred at <b>Pinelawn</b> my, from the causes and on the date stated above.									
23a. SIGNATURE (Registrar's title) <b>Carl J. Klein M.D.</b>				23b. ADDRESS <b>189 King highway</b>			23c. DATE SIGNED <b>9-15-55</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>9/19/55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. Trinity Lutheran</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>			
DATE REC'D BY LOCAL REG. <b>SEP 16 1955</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Buchholz Mortuary 5967 W. Florissant</b>				

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

**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.....  
Signature of Student Embalmer

Signed *William M. Buckley*.....  
Licensed Embalmer No. *755*

P. O. Address *Albany*.....

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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.  
If this body is not embalmed, fact should be so stated above.