

FILED DEC '19 1955 STANDARD CERTIFICATE OF DEATH

State File No. 41699

3058

Registrar's No. 78

BIRTH NO. REG. DIST. NO. PRIMARY REG. DIST. NO.

|  |                                   |   |   |
|--|-----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY St. Charles                                       |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE Missouri b. COUNTY St. Charles |   |
| b. CITY (If outside corporate limits, write RURAL and give township) St. Charles | c. LENGTH OF STAY (In this place) | c. CITY OR TOWN St. Charles   | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital                    |                                   | e. STREET ADDRESS (If rural, give location) Route # 2   |   |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) GEORGE b. (Middle) F c. (Last) MOSELER |  |  | 4. DATE OF DEATH (Month) (Day) (Year) December 8, 1955 |  |  |
|--|--|--|--|--|--|

|             |                        |  |                                |                                    |                           |                         |      |
|-------------|------------------------|--|--------------------------------|------------------------------------|---------------------------|-------------------------|------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH Jan. 13, 1878 | 9. AGE (In years last birthday) 77 | IF UNDER 1 YEAR Months 11 | IF UNDER 24 HRS. Days 9 | Min. |
|-------------|------------------------|--|--------------------------------|------------------------------------|---------------------------|-------------------------|------|

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

|                                   |  |                                     |  |   |  |  |  |
|-----------------------------------|--|-------------------------------------|--|---|--|--|--|
| 13a. FATHER'S NAME Herman Moseler |  | 13b. MOTHER'S MAIDEN NAME Buenemann |  | 14. NAME OF HUSBAND OR WIFE Alma Oelklaus Moseler |  |  |  |
|-----------------------------------|--|-------------------------------------|--|---|--|--|--|

|   |  |                              |  |  |  |  |  |
|---|--|------------------------------|--|--|--|--|--|
| 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 ADDRESS Theodore Moseler, St. Charles, Mo. |  |  |  |
|---|--|------------------------------|--|--|--|--|--|

|   |   |  |  |  |  |  |                                  |  |
|---|---|--|--|--|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fracture of hip subtrochanteric  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH |  |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) Atherosclerotic cardiovascular disease<br>DUE TO (c) Crease |  |  |  |  |  |                                  |  |
|   | 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br>Senility & Kyphosis                                      |  |  |  |  |  | 5 4/10                           |  |

|                        |  |  |  |  |  |  |  |
|------------------------|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION |  | 19b. MAJOR FINDINGS OF OPERATION 4221F |  |  |  | 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) Nov 16 1955 P.m. |  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR? Patient fell |  |
|--|--|--|---|--|---|--|

22. I hereby certify that I attended the deceased from Nov 16, 1955, to 12-8, 1955, that I last saw the deceased alive on 12-8, 1955, and that death occurred at 4:15 P. m., from the causes and on the date stated above.

|  |  |  |                             |  |  |                               |  |  |
|--|--|--|-----------------------------|--|--|-------------------------------|--|--|
| 23a. SIGNATURE (Degree or title) Russell Glider M.D. |  |  | 23b. ADDRESS St. Charles Mo |  |  | 23c. DATE SIGNED Dec 10, 1955 |  |  |
|--|--|--|-----------------------------|--|--|-------------------------------|--|--|

|  |  |                         |  |  |  |  |  |
|--|--|-------------------------|--|--|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial |  | 24b. DATE Dec. 11, 1955 |  | 24c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery |  | 24d. LOCATION (City, town, or county) (State) St. Charles, Mo. |  |
|--|--|-------------------------|--|--|--|--|--|

|                                      |  |                                      |  |      |  |   |  |
|--------------------------------------|--|--------------------------------------|--|------|--|---|--|
| DATE REC'D BY LOCAL REG. Dec 11 1955 |  | REGISTRAR'S SIGNATURE Fannie Russell |  | L 24 |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Arthur C. Rowe, St. Charles, Mo. |  |
|--------------------------------------|--|--------------------------------------|--|------|--|---|--|

(Licensed Embalmer's Statement on Reverse Side)

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

JAN 6 1956

FEB 8 1956

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 *Lawrence M. Butler*.....  
Licensed Embalmer No. *437*.....

P. O. Address *D. Charles*.....

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.