

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

10765

FILED MAR 28 1957

State File No. \_\_\_\_\_  
 Registrar's No. **1754**

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>1754</b>	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>5 Months</b>		c. CITY OR TOWN <b>St. Johns</b>		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>Missouri Baptist Hospital</b>				STREET ADDRESS (If rural, give location) <b>9004 St. Charles Rd.</b>			
3. NAME OF DECEASED (Type or Print) <b>Gerhard A. Moellenhoff</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 19, 1957</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>June 17 1888</b>	
9. AGE (in years last birthday) <b>68</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 14 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet Maker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Cabinet Maker</b>			11. BIRTHPLACE (City and State or Foreign Country) <b>Muenster Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13a. FATHER'S NAME <b>Theodore Moellenhoff</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Mary T. Moellenhoff</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>498 22 1986</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mary T. Moellenhoff 9004 St. Chas. Rd.</b>			
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) <b>Lung abscess</b>				INTERVAL BETWEEN ONSET AND DEATH <b>9-6-56 to 2-19-57</b>			
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Epidermoid carcinoma right lower alveolus and right upper alveolus with</b> DUE TO (c) <b>cervical metastasis.</b>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>144x</b>							
19a. DATE OF OPERATION <b>9-11-57</b>		19b. MAJOR FINDINGS OF OPERATION <b>Epidermoid carcinoma right lower alveolus and right upper alveolus with cervical metastasis.</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)		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>9-6-56</b> , 19____, to <b>2-18-57</b> , 19____, that I last saw the deceased alive on <b>2-18-57</b> , 19____, and that death occurred at <b>2 A.</b> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Jamies J. Chambers M.D.</b>				23b. ADDRESS <b>4952 Maryland Ave., St. Louis 8, Mo.</b>		23c. DATE SIGNED <b>2-20-57</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Feb 21 1957</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Mount Lebanon Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>	
DATE REC'D BY LOCAL REG. <b>FFR 20 57</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Collier Mortuary 10123 St. Charles Rd</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..... *Sheldon Collier* .....

Licensed Embalmer No. *338*

P. O. Address *1423 St. Lk*

- - 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.