

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS JUL 30 1959

2 6704 59-026968
 STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3537 South Jefferson		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CARL E. MOELLER			4. DATE OF DEATH Month Day Year July 16, 1959				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Jan. 24, 1879	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Gen'l. Practice		11. BIRTHPLACE (City and state or country) Rock Island, Ill.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME J. Fred Moeller			13b. MOTHER'S MAIDEN NAME Augusta Phathauer		14. NAME OF HUSBAND OR WIFE Mrs. Emma A. Winter 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 Mrs. Emma Moeller, 3537 So. Jefferson Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia DUE TO (b) Fractured ribs right Fractured rt. hip Fractured rt. shoulder DUE TO (c) <i>Chronic Bronchitis</i>						INTERVAL BETWEEN ONSET AND DEATH 9 P.M. 3 days 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) O.K. <i>Deer born stars received above injuries + receipt of <u>fractured</u></i>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m. ? 7-13-59	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 1949 home	20f. CITY, TOWN, OR LOCATION St. Louis		COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on 7/15/59. Death occurred at 12:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Edward A. Casor, M.D.			22b. ADDRESS 4401 Hampton Ave.			22c. DATE SIGNED 7/17/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE July 18, 1959	23c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery		23d. LOCATION (City, town, or county) St. Louis County, Missouri.			
24. FUNERAL DIRECTOR Beiderwieden F.H.Inc., 1936 St. Louis			25. DATE RECD. BY LOCAL REG. JUL 18 '59		26. REGISTRAR'S SIGNATURE Karl Smith, M.P. (H.T.)		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1:30-4

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed David R. [Signature]

Licensed Embalmer No. 452

P. O. Address [Signature]

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.