RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-009399

FILED VS MAR 10 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 544 STATE FILE NUMBER

DED

1. PLACE OF DEATH
a. COUNTY ST. LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN COOL-VALLEY — Length of stay in 1b 1 YR. 7 MO.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION HILL-TOP-HOUSE 1301 So. FLORISSANT-R — Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY
c. CITY OR TOWN ST. LOUIS — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) FORMERLY: 1811 NO. 18TH ST. — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First MARY Middle — Last MOELLER
4. DATE OF DEATH Month FEB. Day 17TH Year 1960

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH 6-25-1869
9. AGE (last birthday) 90 YRS. — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE
10b. KIND OF BUSINESS OR INDUSTRY HOME
11. BIRTHPLACE (City and state or country) GERMANY
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME FRED-NUNNEMANN
13b. MOTHER'S MAIDEN NAME UNKNOWN <RUEBE>
14. NAME OF HUSBAND OR WIFE AUGUST-MOELLER <DECD.>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Address FRED-MOELLER = 5026 THRUSH-AV.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH – ?
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 420.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from July 27-1957, to Feb 17-1960 and last saw her/him alive on Feb 17-1960
Death occurred at 11:15 A.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John G McInerney MD
22b. ADDRESS 5014 Thekla Av
22c. DATE SIGNED 2/17/60

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE FEB. 20-1960
23c. NAME OF CEMETERY OR CREMATORY CALVARY-CEMETERY
23d. LOCATION (City, town, or county) ST. LOUIS (State) MO.

24. FUNERAL DIRECTOR Brockland Und. Co. ADDRESS 1827-HOGAN-ST.
25. DATE RECD. BY LOCAL REG. 2-18-60
26. REGISTRAR'S SIGNATURE John C. Murphy MD

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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_____

Licensed Embalmer No. 4108

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.