

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

1003

-62-028973
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. _____ Registrar's No. 7484

FILED AUG 6 1962

1. PLACE OF DEATH
a. COUNTY _____

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN St. Louis Length of stay in 1b 291 days

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION St. Louis Chronic Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY _____

c. CITY OR TOWN St. Louis Inside Limits Yes No

d. STREET ADDRESS (If outside, give location) 1410 Cass: <REAR> Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First ELLEN Middle _____ Last Lola Moeckli

4. DATE OF DEATH Month 7 Day 29 Year 62

5. SEX Female 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 10-3-87 9. AGE (last birthday) 74

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

13a. FATHER'S NAME JOHN - HUTTON 13b. MOTHER'S MAIDEN NAME <UNKNOWN> CAMPBELL 14. NAME OF HUSBAND OR WIFE ROBERT - J - MOECKLI

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 ROBERT. J. MOECKLI = 1410-REAR-CASS-AV. 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) Cerebral arteriosclerosis 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) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebrovascular thrombosis

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 10-11-61 to 7-29-62 and last saw her/him alive on 7/29/1962
Death occurred at 12:30 A M on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [Signature] (Degree or title) _____ 22b. ADDRESS 5800 Arsenal, St. Louis Mo. 22c. DATE SIGNED 7/30/62 (State) _____

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 23b. DATE JULY-31-1962 23c. NAME OF CEMETERY OR CEMETERY UNION-CEMETERY 23d. LOCATION (City, town, or county) BLAND - MO.

24. FUNERAL DIRECTOR Brockland Und. Co. 1827-HOGAN-ST. ADDRESS _____ 25. DATE RECD. BY LOCAL REG. JUL 31 1962 26. REGISTRAR'S SIGNATURE [Signature]

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300 Rev. 4/59
1
2 22
3
4 1
5 1
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7 0
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12 76-0
13

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 J. W. Bentley
Licensed Embalmer No. 7653

P. O. Address H. Lewis & Co

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.