

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

11562 - 62-048598
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11562**

FILED DEC 21 1962

VS 300
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Missouri		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 25 yrs.	c. CITY OR TOWN St. Louis Inside Limits Reside on Farm <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros. Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4424 Alaska Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MINNIE Middle CAROLINE Last MOEHLMAN			4. DATE OF DEATH Month NOVEMBER Day 29 Year 1962
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/14/70
9. AGE (last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Hoyleton, Illinois
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Carl Kleine	
13b. MOTHER'S MAIDEN NAME Katherine Bretenhagen		14. NAME OF HUSBAND OR WIFE Henry Moehlman	
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 Address Miss Alma Moehlman, 4424 Alaska Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of right hip; Generalized Arterio sclerosis; suffered in fall in home on November 26th 1962.			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arterio sclerosis; suffered in fall in home on November 26th 1962.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) accident			PART III. If deceased was female was there a pregnancy in last 90 days. 9040 21 <input type="checkbox"/> Yes <input checked="" 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.) See above	
20c. TIME OF INJURY Hour ? a.m. p.m. Month, Day, Year 11-26-62	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.) 15 Home		20f. CITY, TOWN, OR LOCATION St Louis, Mo	
21. I attended the deceased from _____ to _____ and last saw her/him live on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Joseph M. [Signature]		22b. ADDRESS 1300 Chestnut	22c. DATE SIGNED 12-3-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Dec. 3, 1962	23c. NAME OF CEMETERY OR CREMATORY Immanuel Lutheran Cemetery	23d. LOCATION (City, town, or county) (State) Okawville, Illinois
24. FUNERAL DIRECTOR Beiderwieden F.H.Inc., 1936 St. Louis (6)		25. DATE RECD. BY LOCAL REG. DEC 3- 1962	26. REGISTRAR'S SIGNATURE Loed Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

Carroll

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 *Harve W. Fritz*

Licensed Embalmer No. 3882

P. O. Address St. Louis

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.