DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26312

AUG 5 1940

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1261

1. PLACE OF DEATH:

(a) County ST. LOUIS

(b) City or town PINE LAWN
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 6107 MARGARET AVE
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community 10 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS

(c) City or town PINE LAWN
(If outside city or town limits, write "RURAL")

(d) Street No. 6107 MARGARET AVE
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years

3. (a) PRINT FULL NAME F. JOSEPH MOLLERUS

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife CATHERINE MOLLERUS

6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased SEPT. (Month) 20 (Day) 1869 (Year)

8. AGE: Years 70 Months 10 Days 14 If less than one day ____ hr. ____ min.

9. Birthplace ST. LOUIS CO. (City, town, or county) MO (State or foreign country)

10. Usual occupation RETIRED FARMER

11. Industry or business

FATHER
12. Name JOSEPH MOLLERUS
13. Birthplace ____ (City, town, or county) GERMANY (State or foreign country)

MOTHER
14. Maiden name BERNADINA SCHOELAU
15. Birthplace ____ (City, town, or county) GERMANY (State or foreign country)

16. (a) Informant's own signature Mrs. Catherine Mollerus

(b) Address 6107 Margaret Ave

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY-8-1940 (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEMETERY

18. (a) Signature of funeral director F. B. Tanner

(b) Address 6107 Natural Bridge Rd.

19. (a) JUL 6 - 1940 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4th year 1940 hour 11: minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan. 11, 1936, to July 4, 1940; that I last saw him alive on July 4, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Chr. Generalized Arteriosclerosis, Chr. Coronary Sclerosis, Chr. Myocarditis, Chr. Essential Hypertension, Chr. Hypertensive Heart Disease, Cardiac Enlargement, Chr. Angina Pectoris.

Due to Secondary: Seizure Angina Pectoris; died in the attack.

Duration

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy No

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) --

(b) Date of occurrence --

(c) Where did injury occur? -- (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? --

While at work? -- (Specify type of place) (e) Means of injury --

23. Signature [illegible] M. D. or other)

Address 3718 Jennings Rd. Pine Lawn Date signed 7-6-40

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impo

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Guy Wilkinson

Licensed Embalmer No. 3575

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26312

Registration District No. 784 Primary Registration District No. 200 Registrar's No. 1261

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Pine Lawn (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Frank Joseph Mollerus

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 70 Months 9 Days 14 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director F B Tanner
(b) Address
19. (a) 7-6-40 (Date received local registrar) (b) T R Mayer [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 4 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature L B Turner (M. D. or other)
Address 3718 Jennings Date signed