

No. 2
5-43
17-39
X36671

Registration District No. **FILED JUL 8 1944 8**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. John's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 Days**
(Specify whether years, months or days) **0**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**

(c) City or town **St. Louis** (If outside city or town limits, write "RURAL") **2317**

(d) Street No. **1722 Waverly Place** (If rural, give location) **9**

(e) Citizen of foreign country? (Yes or No) **No**
If yes, name country _____

3. (a) PRINT FULL NAME **Henry A. Molles**

3. (b) If veteran, name war *********

3. (c) Social Security No. **None**

4. Sex **Male** (0) 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widower**

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

7. Birth date of deceased **July 4 1876**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

67 11 21 .hr. min.

9. Birthplace **Illinois** (City, town, or county) (State or foreign country)

10. Usual occupation **Druggist**

11. Industry or business **Self**

12. Name **Andrew Molles**

13. Birthplace **Switzerland** (City, town, or county) (State or foreign country) **5**

14. Maiden name **Barbara Pfiffner**

15. Birthplace **Illinois** (City, town, or county) (State or foreign country) **1**

16. (a) Informant **Missie Berke**

(b) Address **1906 E. John Ave**

17. (a) **Removal** (Burial, cremation, or removal) (b) Date thereof **June 28 1944**
(Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Calvary Shiloh Ill**

18. (a) Signature of funeral director **Peetz Brothers**
3029 Lafayette Ave

(b) Address **JUN. 27 1944** **J. F. Bredisch**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **25th** day **June**
year **1944** hour **12:00** minute **A.** M.

21. I hereby certify that I attended the deceased from **6-22-1944** to **6-25-1944**
that I last saw him alive on **6-24-1944**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Yellow Atrophy of Liver**

Due to **Acute Yellow Atrophy of Liver**

Due to **Cause unknown**

Other conditions (Include pregnancy within 3 months of death) **125-2**

Major findings: Of operations _____

Of autopsy _____

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) _____

(c) Means of injury _____

23. Signature **Carl H. ...** (M. D. or other) **6-27-44**
Address **...** Date signed **6-27-44**

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....
Paul J. Swann

Licensed Embalmer No..... *2245*

P. O. Address..... *2010 W. 1st St*

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 this body is not embalmed, fact should be so stated above.