

FILED JUL 26 1944

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: **Christian Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 week** (Specify whether)
In this community **Since Birth** (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
(d) Street No. **4340 Gano Avenue** (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **SYLVESTER MOLL**
(b) If veteran, name war **None**
(c) Social Security No. **4885 12-5484**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **18**
1944 year hour **4** minute **10** PM M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
(b) Name of husband or wife **Helen Moll (nee Jobe)**
(c) Age of husband or wife if alive **35 yrs** years
7. Birth date of deceased **March 17, 1897**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **July 9** 19**44** to **July 18** 19**44**
that I last saw him alive on **July 18** 19**44**
and that death occurred on the date and hour stated above.

8. AGE: Years **47** Months **4** Days **1**
If less than one day hr. min.

Immediate cause of death
Hypostatic pneumonia 1 day
Due to **irritated ischio rectal abscess 10 days**
Due to **acute pancreatitis 10 days**
Other conditions **chronic alcoholism 28**
(Includes pregnancy within 3 months of death)

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

Major findings: Of operations **ischio rectal abscess**
Of autopsy **Hypostatic pneumonia, acute pancreatitis, fatty liver**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation **Salesman**

11. Industry or business **Dyer-Moon Co. Commission Business**

12. Name **Not Known**

13. Birthplace **Not Known**
(City, town, or county) (State or foreign country)

14. Maiden name **Not Known**

15. Birthplace **Not Known**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Hattie Moll**
(b) Address **4340 Gano Avenue**

17. (a) Burial (b) Date thereof **7/21/44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Friedens Cemetery**

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)

18. (a) Signature of funeral director **Math. Hermann & Son**
(b) Address **2161 East Fair Avenue**

While at work? _____ (c) Means of injury **md**
23. Signature **J. F. Brueck** (M. D. or other) **md**
Address **4200 Grand Blvd** Date signed **7/19/44**

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

MOTHER FATHER

BY M. J. O'NEIL

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.

Signature *Gustav W. Reiche*

Licensed Embalmer No. *4329*

P. O. Address.....

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.