

FILED FEB 7 1945  
Registration District No. 318

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(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. One day  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Emma C. Moeller

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female

5. Color or race Wh

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

6. (b) Name of husband or wife. Julius F. Moeller

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased. February 1 1875  
(Month) (Day) (Year)

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

69	11	25	_____ hr. _____ min.
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9. Birthplace. St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation. Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Wm. Brockman

{ 13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

{ 14. Maiden name Caroline Dreyer

{ 15. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Julius F. Moeller

(b) Address 3910 Maffitt Ave

17. (a) Burial (b) Date thereof Jan 29 '45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cemetery

18. (a) Signature of funeral director. Kraeger-Voss-Fix

(b) Address 3402 No. Kingshighway

19. (a) JAN 27 1945 (b) J. F. Bredebeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mad

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

(d) Street No. 3910 Maffitt Ave  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 25th  
year 1945 hour 2 minute 45 A. M.

21. I hereby certify that I attended the deceased from Oct 28, 1945, to Jan 27, 1945  
that I last saw her alive on Jan 24, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Bronchitis Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions chronic Myocarditis  
(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature H. H. Hemmer (M. D. or other) MD  
Address 4362 Warr Date signed 1-25-45

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**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

*John Agonowski*

Licensed Embalmer No. *2398*

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.**