

S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6724

State File No. _____

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2217**

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

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: 3905th N. 20th St. - 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 1/2 weeks (Specify whether)
In this community 28 years (Specify whether)
years, months or days

3. (a) PRINT FULL NAME LEVI MOGLER
(b) If veteran, name war NIN (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MOULIE MOGLER 6. (c) Age of husband or wife if alive 76 years
7. Birth date of deceased NOV. 16, 1860
(Month) (Day) (Year)

8. AGE: Years 86 Months 3 Days 17 If less than one day hr. min.

9. Birthplace JACKSON MO
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED

11. Industry or business NIL

MOTHER FATHER
12. Name UNK. MOGLER
13. Birthplace UNK. UNK.
(City, town, or county) (State or foreign country)
14. Maiden name UNK.
15. Birthplace UNK. UNK.
(City, town, or county) (State or foreign country)

16. (a) Informant MOULIE MOGLER
(b) Address 3905th N. 20th St.

17. (a) Burial Removal (b) Date thereof 3/7/46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation CAPE GIRARDEAU, MO

18. (a) Signature of funeral director W. D. Meyer 9 Cona
(b) Address 3934 N. 20th St.

19. (a) MAR 4 1947 (b) J. F. Bradeck
(Date received by Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County 000
(c) City or town ST. LOUIS 2517
(If outside city or town limits, write "RURAL")
(d) Street No. 3905th N. 20th St. 9
(If rural, give location)
(e) Citizen of foreign country? _____ (If yes, name country) (Specify whether)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 3^d
year 1947 hour 11.50 minute A. M.

21. I hereby certify that I attended the deceased from Dec 4th 1947, to March 3rd 1947,
that I last saw him alive on February 24 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Senile aortal Sclerosis } Duration Part
Chon. Myocarditis } 3
Due to (Immunition) } Months
Chon. Bronchitis
Due to Under nourished
Gastro Intestinal disorders
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations: _____
Of autopsy: _____
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 Phil M. Taylor (M. D. or other) 3/4/47
Address 4444 N. Grand Date signed

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..... *A. A. Smothers*.....

Licensed Embalmer No. *3916*.....

P. O. Address. *3934 N. 20 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.