

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3520

FILED JAN 28 1953

318

1003

State File No.

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. 33

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Christian	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Taylorville <u>8120</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <u>8</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)			
a. (First) Gus			b. (Middle)			
c. (Last) Mollet Jr			Jan 2 1953			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar 27, 1895	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Brazil Ind		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Gus Mollet Sr		13b. MOTHER'S MAIDEN NAME Mary Stickels		14. NAME OF HUSBAND OR WIFE Nettie Mollet	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. Unk		17. INFORMANT'S SIGNATURE OR NAME ADDRESS John Lacey Georgetown Ill	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Decedent Ulcer and peritonitis		2 MO.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUE TO (b)			
		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION 12/18/52		19b. MAJOR FINDINGS OF OPERATION as above		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 5410	

22. I hereby certify that I attended the deceased from 12/4/52, 1952 to 1/2/53, 1953, that I last saw the deceased alive on 1/1/53, 1953, and that death occurred at 6:40 p.m., from the causes and on the date stated above.

23. SIGNATURE (Type or Print) Rae Sauer, M.D.		23b. ADDRESS 634 N. Grand St. L. Mo		23c. DATE SIGNED 1/3/53	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 1-3-53		24c. NAME OF CEMETERY OR CREMATORY City	
				24d. LOCATION (City, town, or county) (State) Georgetown Ill	

DATE RECD BY LOCAL REG. JAN 3 1953		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington	
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(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

John S. Blume
Licensed Embalmer No. 4194
P. O. Address St. Louis

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.