

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 2 - 1955

State File No. **2876**
Registrar's No. **0457**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 0457					
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri				b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>				
d. FULL NAME OF HOSPITAL OR INSTITUTION. St. John Hospital O				e. STREET ADDRESS (If rural, give location) 2237 1126 Sidney St.							
3. NAME OF DECEASED (Type or Print) a. (First) Arnold			b. (Middle) Julius			c. (Last) Moeckel			4. DATE OF DEATH (Month) (Day) (Year) January 16, 1955		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced		8. DATE OF BIRTH December 9, 1885		9. AGE (In years last birthday) 69	10. MONTHS 1	11. DAYS 7	12. HOURS & MIN. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (City and State or Foreign Country) Frouna, MO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Charles Moeckel			13b. MOTHER'S MAIDEN NAME Not known			14. NAME OF HUSBAND OR WIFE _____					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 493-10-8092			17. INFORMANT'S SIGNATURE OR NAME Lovearn Moeckel ADDRESS 6738 Dale Ave.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		<p align="center">MEDICAL CERTIFICATION</p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bilateral Pneumonia</p> <p>ANTECEDENT CAUSES</p> <p>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</p> <p>DUE TO (b) Post-operative (Gastric Resection)</p> <p>DUE TO (c) Bleeding duodenal ulcer</p> <p>II. OTHER SIGNIFICANT CONDITIONS</p> <p>Conditions contributing to the death but not related to the disease or condition causing death.</p>							INTERVAL BETWEEN ONSET AND DEATH 1 day 2 days 1 wk.		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____							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) _____		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 Jan 10, 1955 to 1-16, 1955 , that I last saw the deceased alive on 1-15, 1955 , and that death occurred at 8 A m., from the causes and on the date stated above.											
23a. SIGNATURE Arthur K. Jurek M.D. (Degree or title)				23b. ADDRESS 1850 Kenilworth				23c. DATE SIGNED 1-17-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1/18/55		24c. NAME OF CEMETERY OR CREMATORY Local Cemetery			24d. LOCATION (City, town, or county) (State) High Ridge, Mo.				
DATE REC'D BY LOCAL REG. JAN 17 1955		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John H. Gebken Sons 2630 Gravois Ave.					

S. P. (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.....
Signature of Student Embalmer

Signed *Robert T. Gebken*

Licensed Embalmer No. *4145*

P. O. Address *2630 Ave*

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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.
If this body is not embalmed, fact should be so stated above.