

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023632
STATE FILE NUMBER

FILED JUL 3 1959

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 1742

300
1-57

| | | | |
|---|------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Webster Groves</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hosp.</u> | | Length of stay in 1b <u>5 wks.</u> | d. STREET ADDRESS (If outside, give location) <u>641 Barstow</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>J. LOREN MOLLER</u> | | | 4. DATE OF DEATH Month Day Year <u>June 29, 1959</u> |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 4, 1888</u> |
| 9. AGE (In years last birthday) <u>70</u> | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Manager</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Chapman Clnrs.</u> | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13a. FATHER'S NAME <u>Joseph Moller</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Wilmot Pemberghy</u> | | 14. NAME OF HUSBAND OR WIFE <u>Myra C. Moller</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>488-05-0440</u> | 17. INFORMANT Address <u>Glean L. Moller, 298 Elm, Glendale</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Multiple thromboses</u> DUE TO (c) <u>Carcinoma of pancreas</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>5 days</u> <u>3 months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized arteriosclerosis and nephritis</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>157X</u> | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from <u>4-17-59</u> to <u>6-29-59</u> and last saw him alive on <u>6-28-59</u> Death occurred at <u>4:45 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>Charles Miller MD</u> | | 22b. ADDRESS <u>206 N. Clay, Kirkwood, Mo.</u> | 22c. DATE SIGNED <u>6-30-59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | 23b. DATE <u>7-1-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u> |
| 24. FUNERAL DIRECTOR <u>Parker-Aldrich, Webster Groves</u> | | 25. DATE RECD. BY LOCAL REC. <u>6-30-59</u> | 26. REGISTRAR'S SIGNATURE <u>John C. Murphy MD</u> |

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Gustav W. Guterle*

Licensed Embalmer No. *4329*
P. O. Address *St Louis Mo*

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.