

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9395**

FILED OCT 26 1961

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, give TOWNSHIP only) OR TOWN ST LOUIS,		c. CITY OR TOWN ST LOUIS,	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST JOHN'S HOSPITAL		d. STREET ADDRESS (If outside, give location) 6552 WINONA AVE	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First JOHN Middle M. Last MOLL			4. DATE OF DEATH Month OCT , Day 8 , Year 1961		
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5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/12/1892	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUP. PUBLIC SERVICE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MISSOURI	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME MICHAEL MOLL	13b. MOTHER'S MAIDEN NAME T. UNKNOWN	14. NAME OF HUSBAND OR WIFE MARY L. (MAYME)
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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.	17. INFORMANT MARY L. (MAYME) MOLL	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		6552 WINONA AVE	INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<i>Cerebral Infarction by thrombosis</i>		<i>4 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	<i>Cerebral arteriosclerosis</i>	<i>4 yrs</i>
	DUE TO (c)	<i>332x</i>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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
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21. I attended the deceased from *May 2, 1947* to *Oct 8, 1961* and last saw him alive on *Oct 8, 1961*
 Death occurred at *11 p* m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>John S. Matthew M.D.</i>	22b. ADDRESS <i>370 Swatson Rd</i>	22c. DATE SIGNED <i>10-14-61</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10/12/61	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	23d. LOCATION (City, town, or county) (State) ST LOUIS MISSOURI
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24. FUNERAL DIRECTOR STROOT - CARROLL	ADDRESS 4600 NAT'L BRIDGE	25. DATE RECD. BY LOCAL REG. OCT 11 1961	26. REGISTRAR'S SIGNATURE <i>Loan Smith M.D.</i>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Matthews
3707
Pr 13886
1 to 4
Watson

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 M W Ruster

Licensed Embalmer No. 4865
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.