

SEP 26 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

27737

1. PLACE OF DEATH

County St. Francois
Township St. Francois
City Near Farmington, Mo.

Registration District No. 773
Primary Registration District No. 6018A

File No. _____
Registered No. 131
St. _____ Ward)

2. FULL NAME Rose Mueller

(a) Residence. No. De Soto, Mo. St. _____ Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Unknown

7. AGE

YEARS

MONTHS

DAY

If LESS than 1 day, _____ hrs. or _____ min.

77

?

?

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Mehlville

(STATE OR COUNTRY) Mo.

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Germany

14. INFORMANT Hospital Records

(Address) Farmington, Mo.

15. FILED 8-29-30 J. Robinson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 28, 1930

17. I HEREBY CERTIFY, That I attended deceased from June 14, 1930, to Aug 28, 1930.
that I last saw her alive on Aug 27, 1930, and that death occurred, on the date stated above, at 7:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy (cerebral)

92 hr
16? (duration) yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

Senility (duration) yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Paul Hanks, M. D.

8/28, 1930 (Address) Farmington Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

City Cen. De Soto Mo 8/30/30

20. UNDERTAKER

ADDRESS

Cornell Dietrich De Soto Mo

Exact statement of OCCUPATION is very important. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified.

