

REC'D MAR 13 1939

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

4611
Do not use this space.

1304

1. PLACE OF DEATH

(a) County..... Registration District No. 791
(b) Township..... Primary Registration District No. 1003
(c) City ST. LOUIS (d) Street No. LUTHERAN HOSPITAL St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 20 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 466 FRANK MUELLER

(a) Residence, No. 4465 NEOSHO St. 15 (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) AUG. 23, 1886

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
52 5 14

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Cabinet maker

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) Feb. 2, 1939 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) GERMANY

13. NAME JOSEPH MUELLER

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) GERMANY

15. MAIDEN NAME ANNA HAMPEL

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) GERMANY

17. INFORMANT Henrietta Mueller (ADDRESS) 4465 Neosho

18. BURIAL, CREMATION, OR REMOVAL

PLACE MO. CREMATORY DATE 2/10/39

19. FUNERAL DIRECTOR (NAME) Oscar J. Hoffmeister (ADDRESS) 4016 Chippewa St.

20. FILED FEB 9 1939 J. E. Budek Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 7, 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1939, to Feb. 7, 1939

I last saw him alive on Feb. 7, 1939. Death is said to have occurred on the date stated above, at 4:50 P.M.

The principal cause of death and related causes of importance were as follows:

Paralytic Ileus

Date of onset 2/2/39

Other contributory causes of importance:

Ruptured appendix
Peritonitis

Name of operation Appendectomy Date of 2/2/39
What test confirmed diagnosis? Clinical Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) Pierce W. Powers, M. D.

(Address) 2531 So. Jefferson

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. *4249*

P. O. Address..... *4016 Chippewa*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.