

Registration District No. 791 Primary Registration District No. 1003

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. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:

(a) County M

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2304 Montgomery St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community About 52 years

3. (a) PRINT FULL NAME Margaret Mueller

8. (b) If veteran, name war no 8. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Henry G. Mueller 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased Mar. 28, 1866
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>10</u>	<u>17</u>	hr. min.

9. Birthplace Belleville Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Charles Dinges

13. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

14. Maiden name Katherina Meier

15. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Fanny G. Mueller

(b) Address 2304 Montgomery St

17. (a) Burial (b) Date thereof Feb. 19, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Booker L. Bookhart

(b) Address 2228 St. Louis Ave

19. (a) Feb 18 1940 (b) _____
(Date received for burial) (City or town)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis 20
(If outside city or town limits, write "RURAL")

(d) Street No. 2304 Montgomery St.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 15th
year 1940 hour 9 minute 15 A.M.

21. I hereby certify that I attended the deceased from Aug 15, 1939 to Feb 15, 1940
that I last saw her alive on Feb 14, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u> cerebral haemorrhage</u>	<u>5 da.</u>
<u> cerebral sclerosis</u>	<u>4 yr.</u>
<u> cerebral haemorrhage</u>	
<small>(Include pregnancy within 3 months of death)</small> <u>1936 - 1937.</u>	

PHYSICIAN

Major findings: _____
Of operations: _____
Of autopsy: _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. D. Parks (M. D. or other) _____
Address 12505 No. Tenth Date signed 3/17/40

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

Charles Goodrich

Licensed Embalmer No. *2777*

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