No. 2
-10-39
7-39
X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED 5

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1940 MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29596

Registration District No. 784 Primary Registration District No. 104 Registrar's No. 1549

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
At home on Hudson Road 2
(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 ____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Ferguson,
(If outside city or town limits, write "RURAL")

(d) Street No. Hudson Rd. Route 10 Box 919.
(If rural, give location)

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

3. (a) PRINT FULL NAME Sebastian W. Mueller 460

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Elizabeth Mueller

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased July 21, 1863. (Month) (Day) (Year)

8. AGE: Years 77 Months 0 Days 24 If less than one day ____ hr. ____ min.

9. Birthplace Switzerland ? (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business ____

FATHER
12. Name Sebastian Mueller Sr.
13. Birthplace Switzerland ? (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Anna ?.
15. Birthplace Switzerland ? (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Elizabert Mueller
(b) Address Route 10, Ferguson, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 17/40. (Month) (Day) (Year)
(c) Place: burial or cremation Florissant, Mo.

18. (a) Signature of funeral director Jos. W. Clark,
(b) Address 1125 Hodiamont Ave.

19. (a) AUG 14 1940 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 14 year 1940 hour 2.10 minute A.M. M.

21. I hereby certify that I attended the deceased from Oct. 29, 1937 to Aug. 9, 1940; that I last saw him alive on Aug. 9 1940; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Cardio-Vascular-	
Renal disease, Malignant Hypertension	?
Secondary:	
~~Due to~~ General Anasarca	About 2 yrs.
Uremia, Uremic Coma	1 mo.
~~Due to~~ Myocardial Decompensation	1 yr.

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

PHYSICIAN — 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) No
(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? -- (Specify type of place)
While at work? (e) Means of injury

23. Signature [illegible] M. D. or other) M.D.
Address 3718 Jennings Rd., Pine Lawn Date signed 8-14-40

N. B. (Licensed Embalmer's Statement on Reverse Side)

Dr. L.B.Tiernon
3718 Jennings Rd.,
Ev. 1968.

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

Mark L. Tiernon, Registered Apprentice No. 174

working under my personal supervision.

Signed [signature]

Licensed Embalmer No. 3225.

P. O. Address 1125 Hodiamont Ave.,

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

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

OCT 14 1968