

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

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.

Registration District No. 2011

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3705 Wyoming 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)

FILED DEC 11 1940

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3705 Wyoming St  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

8. (a) PRINT FULL NAME Josephine Mueller

8. (b) If veteran, name war \*\*\*\*\* 8. (c) Social Security No. \*\*\*\*\*

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

6. (b) Name of husband or wife Leo Mueller 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 29 1862  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
78 5 23 hr. min.

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

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name Mathais Mentrup

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

14. Maiden name Unknown  
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Mrs. Joe Schlicht

(b) Address 3705 Wyoming St

17. (a) Burial (b) Date thereof Nov 25 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter and Paul

18. (a) Signature of funeral director Pestz Brothers

(b) Address 3029 Lafayette Ave

19. (a) NOV 25 1940 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 22nd day November  
year 1940 hour 2:53 minute P. M.

21. I hereby certify that I attended the deceased from March, 1940, to Nov 21, 1940  
that I last saw her alive on November 21, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Mitralitic Carcinoma  
medullarum

Due to Carcinoma of R  
Heart

Due to (Inoperable)

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

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) \_\_\_\_\_

(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 \_\_\_\_\_

28. Signature Henry G. Farrell (M. D. or other) \_\_\_\_\_

Address 6094 Grand Date signed 11/24/40

Dr. W. A. Marshall  
3826. Castleman

Je - 0402  
Ka - 1150

9648  
8796

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 Frank J. Owens

Licensed Embalmer No. 22245

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.