

No. 2  
4-13-40  
5-17-39  
I X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
APR 21 1941  
791

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 9062  
Registrar's No. 2472

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:  
(a) County.....  
(b) City or town. **St. Louis**  
(c) Name of hospital or institution:  
**5882 Julian Ave.**  
(d) Length of stay: In hospital or institution.....  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME. **Dora J. Mueller**  
3. (b) If veteran, name war.....  
3. (c) Social Security No.....

4. Sex **Female /** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife. **Fred C. Mueller Sr.**  
6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased.....  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**81 10 9** hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business.....

MOTHER FATHER { 12. Name **Unknown**  
13. Birthplace **Unknown**  
14. Maiden name **Unknown**  
15. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **J. M. Beck Jr.**  
(b) Address **5882 Julian Ave**

17. (a) **Burial** (b) Date thereof **3-20-41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bellefontaine Cem.**

18. (a) Signature of funeral director **Drehmann-Harral**  
(b) Address **1905 Union Blvd.**

19. (a) **MAR 19 1941** (b) **J. M. Beck**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo.** (b) County **0 000**  
(c) City or town. **St. Louis**  
(If outside city or town limits, write "RURAL") **17**  
(d) Street No. **5882 Julian Ave.**  
(If rural, give location) **9**  
(e) If foreign born, how long in U. S. A.? **0** years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Mar.** day **17**  
year **1941** hour **11** minute **50** P.M.  
21. I hereby certify that I attended the deceased from **3-16-41**  
to **3-17**, 19**41**,  
that I last saw her alive on **3-17**, 19**41**,  
and that death occurred on the date and hour stated above.

Immediate cause of death  
**Heart disease**  
**chronic myocarditis**  
**arteriosclerosis**  
Due to.....  
Due to.....  
Other conditions **seizure 936**  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings:  
Of operations.....  
Of autopsy **Alcohol present**  
**John Corrier 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).....  
(c) Means of injury.....  
23. Signature **Wayne J. [unclear]** (M. D. or other) **MD**  
Address **27391 No 172nd** Date signed **3-10-41**

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

2732 N Grand  
1-3 5-7-8  
Spencer Med.

**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 Warren A. Carver

Licensed Embalmer No. 353X

P. O. Address.....

**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, fact should be so stated above.**