

FILED DEC 7 1944  
306

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registrar's No. 2231

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

Primary Registration District No. 6048

38669

1. PLACE OF DEATH:

(a) County St. Charles  
(b) City or town O'Fallon, St. Charles Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Mary's Institute  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Charles  
(c) City or town O'Fallon 92  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 10

3. (a) PRINT FULL NAME SISTER MARY HELEN, FRIEDOLINE 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 single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 3 1864  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
80 8 8 hr. min.

9. Birthplace Barr 5 Switzerland  
(City, town, or county) (State or foreign country)

10. Usual occupation Domestic Work

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

MOTHER FATHER { 12. Name John Mueller  
13. Birthplace Barr 5 Switzerland  
(City, town, or county) (State or foreign country)  
14. Maiden name Elisabeth not known  
15. Birthplace Barr 5 Switzerland  
(City, town, or county) (State or foreign country)

16. (a) Informant Sister M. Bershman

(b) Address O'Fallon, Mo

17. (a) Burial (b) Date thereof 11 16 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Convent Cemetery

18. (a) Signature of funeral director Chas. B. Hallmeyer  
(b) Address 801 N. 2nd St. St. Charles Mo

19. (a) 11/14/44 (b) E. A. Kautsky  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 14  
year 1944 hour 2 minute A. M.

21. I hereby certify that I attended the deceased from JULY 1938, to NOV. 14 1944.  
that I last saw her alive on NOV. 12 1944.  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Broncho pneumonia 3 days  
Myocarditis 10 yrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Fractured Rt. hip APRIL 1944  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

Duration  
APRIL 1944  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence APRIL 1944

(c) Where did injury occur? O'FALLON ST. CHARLES MO.  
(City or town) (County) (State)

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

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

23. Signature Nicholas J. Norwich (M. D. or other) 11/13/44  
Address O'Fallon, Mo Date signed

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 12-5-44

**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 John E. Hallmeyer

Licensed Embalmer No. 2951

P. O. Address St Charles 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, fact should be so stated above.**

Registration District No. 306

Primary Registration District No. 6048

Registrar's No. 223

**1. PLACE OF DEATH:**  
 (a) County St Charles  
 (b) City or town O'Fallon St. Charles Mo  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_ years, months or days

**3. (a) PRINT FULL NAME:** Sister Mary Helen Freda Mueller  
 3. (b) If veteran, name war \_\_\_\_\_ No. \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased March 6 (Month) (Day) (Year)

8. AGE: Years 80 Months 8 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month Nov - Day 15 year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
 that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Fracture of hip  
 (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

**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) Accidental fall  
 (b) Date of occurrence March 21 1948  
 (c) Where did injury occur? O'Fallon St. Charles Mo  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Convent home  
 While at work? No (Specify type of place) (e) Means of injury Fall  
 23. Signature Nicholas J. Honich (M. D. or other) \_\_\_\_\_  
O'Fallon Mo Date signed 12/16/48  
 Address \_\_\_\_\_

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

SUPPLEMENTARY

386069