

FILED APR 10 1946  
199

Registration District No. 199 Primary Registration District No. 1002

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution: General Hospital No. 10  
(d) Length of stay: In hospital or institution 3 days  
In this community 76 years

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City 3  
(d) Street No. 1709 Bristol 7  
(e) Citizen of foreign country? None (Yes or No) ?

3. (a) PRINT FULL NAME Otto Mueller  
3. (b) If veteran, name war no  
3. (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 29  
year 1946 hour 11 minute 27 A. M.  
21. I hereby certify that I attended the deceased from March 26, 1946 to March 29, 1946  
that I saw him alive on March 29, 1946  
and that death occurred on the date and hour stated above.

4. Sex M. 5. Color or race Wh.  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Belara  
6. (c) Age of husband or wife if alive - years  
7. Birth date of deceased Aug. 13, 1869

Immediate cause of death Arteriosclerotic heart disease  
Due to  
Due to  
Other conditions (include pregnancy within 3 months of death)  
Major findings: Of operations  
Of autopsy None  
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?  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

8. AGE: Years 76 Months 7 Days 16  
If less than one day hr. min.

9. Birthplace K. Mo. (City, town, or county) no (State or foreign country)

10. Usual occupation Paperhanger  
11. Industry or business Self

MOTHER FATHER  
12. Name August Mueller 4  
13. Birthplace Germany  
14. Maiden name Belara Warnick  
15. Birthplace Germany

16. (a) Informant Mabel Lueinen  
(b) Address 25 1/2 W. Overton

17. (a) Burial (b) Date thereof 4-1-46  
(c) Place: burial or cremation Wash. Washington

18. (a) Signature of funeral director B. Blackman  
(b) Address no

19. (a) 4-1-46 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
23. Signature Wm W Hart (Specify type of place) Med. Dir. Gen'l Hosp.  
Address Med. Dir. Gen'l Hosp. Date signed 5-30-46

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

*de Marco*

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**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 *H. D. Blackman*

Licensed Embalmer No. *3639*

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.**