

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26319**

FILED JUL 23 1947

Registration District No. **2677**

Primary Registration District No. **6076**

Registrar's No. **1031**

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Overland, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
9216 Midland  
(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) 6 yr 7 mo 16 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Overland  
(If outside city or town limits, write "RURAL")  
(d) Street No. 8928 Argyle  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Henrietta Mueller

3. (b) If veteran, name war..... 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Jacob Mueller Jr. 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased December 22 1862  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
84 6 16 hr. min.

9. Birthplace London England 4  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER

12. Name George Diederich 4  
13. Birthplace Germany (City, town, or county) (State or foreign country)  
14. Maiden name Unknown 4  
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. A. Westburry

(b) Address 8907 Sycamore Court

17. (a) Burial (b) Date thereof July 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Ortmann Funeral Home

(b) Address 9222 Lackland Ave.

19. (a) 7-17-47 (b) Cecelia J. Sharpe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16  
year 1947 hour 11 minute 15 AM  
21. I hereby certify that I attended the deceased from May 7 1947  
to July 16 1947  
that I last saw her alive on July 7 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 10 min

Due to arterio sclerosis generalized

Due to hypertension 830

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).....  
(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.....

23. Signature Paul B. Vatterud (M. D. or other) M.D.  
Address 10300 St Charles Rd Date signed July 16 1947

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

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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.....

*Henry A. Brammer*  
.....  
Licensed Embalmer No. 4200

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.**