

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3069

State File No. 987

318

1003

Registrar's No.

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION 1417 Benton St				d. STREET ADDRESS (If rural, give location) 1417 Benton St.			
3. NAME OF DECEASED (Type or Print) a. (First) Otto		b. (Middle) E.		c. (Last) Mueller		4. DATE OF DEATH (Month) (Day) (Year) 1 30 1949	
5. SEX male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Sept. 24- 1878.	
9. AGE (In years last birthday) 70		10. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) St. Louis Mo		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME William Mueller			13b. MOTHER'S MAIDEN NAME Ann Locke			14. NAME OF HUSBAND OR WIFE Kate Mueller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Kate Mueller 1417 Benton St.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cerebral arterial accident ANTECEDENT CAUSES Morbidity conditions if any arising rise to the above cause by making the underlying cause age. DUE TO (b) Arteriosclerosis DUE TO (c) Arteriosclerotic heart disease II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Previous cerebral accidents				INTERVAL BETWEEN ONSET AND DEATH 24 hrs. long standing 5 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 32 N				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 29 Jan, 1949, to 30 Jan, 1949, that I last saw the deceased alive on 30 Jan, 1949, and that death occurred at 6:30 p. m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) M. D. M. D.				23b. ADDRESS 3633 N. Newland		23c. DATE SIGNED 1 Feb 49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2-2-49		24c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County Mo	
DATE REC'D BY LOCAL REG. FEB 1		REGISTRAR'S SIGNATURE J. B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hy. Leidner U. 2223 St. Louis Ave			

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

2/6

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed John P. Buchholz

Licensed Embalmer No. 1674

P. O. Address 2223 St. Louis

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.