

FILED MAR 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7733

BIRTH NO. _____		REG. DIST. NO. <u>91</u>		PRIMARY REG. DIST. NO. <u>3012</u>		Registrar's No. <u>32</u>		
1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs</u>			c. LENGTH OF STAY (in this place) <u>4 wks</u>			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Excelsior Springs Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>514 Benton Street</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>FANNY</u>			b. (Middle) <u>ELLEN</u>		c. (Last) <u>MUELLER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 1, 1949</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 20, 1880</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>Excelsior Springs, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Francis M. Harris</u>			13b. MOTHER'S MAIDEN NAME <u>Merv Susan Unger</u>		14. NAME OF HUSBAND OR WIFE <u>Emil Mueller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>283-20-4967</u>		17. INFORMANT'S SIGNATURE OR NAME <u>John Mueller, 5437 Holmes, K.C. Mo.</u>				
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral accident</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Multiple emboli -</u> <u>Auricular fibrillation</u> DUE TO (c) <u>Hypertension - toxic gastritis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fr. neck rt. femur.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>9:03</u> <u>12 yrs</u>	
19a. DATE OF OPERATION <u>5 Feb 49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Intra capsular Fracture - neck of femur rt.</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Hospital</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Excelsior Springs Clay Mo.</u>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Feb 4, 1949</u> m.		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fall.</u>				
22. I hereby certify that I attended the deceased from <u>4 Feb</u> , 19 <u>49</u> , to <u>1 Mar</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>2 Mar</u> , 19 <u>49</u> , and that death occurred at <u>9:30 a.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>George E. Sanders MD</u>				23b. ADDRESS <u>Excelsior Spgs. Mo.</u>		23c. DATE SIGNED <u>2 Mar 49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Mar. 4, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>3/4/49</u>		REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Claude Richard, Ex. Springs, Mo.</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

24

No. 300
10. 48

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

3-22-49

SEP 17 1949

OCT 28 1949

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 _____

Robert Carbin White

Licensed Embalmer No. 4168

P. O. Address Excelsior Springs

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.