

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4125**

No. 300

FILED MAY 13 1949

10-48

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis				c. LENGTH OF STAY (in this place) _____			
d. FULL NAME OF HOSPITAL OR INSTITUTION 4056 Blaine Ave.				d. STREET ADDRESS (If rural, give location) 4056 Blaine Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) Rev. Theophile L. Mueller			b. (Middle) _____			c. (Last) _____	
4. DATE OF DEATH May 7, 1949			5. SEX Male		6. COLOR OR RACE White		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married			8. DATE OF BIRTH March 5, 1863		9. AGE (In years last birthday) 86		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pastor			10b. KIND OF BUSINESS OR INDUSTRY Pastor		11. BIRTHPLACE (State or foreign country) Oakaville, Ill		
12. CITIZEN OF WHAT COUNTRY? Am.			13a. FATHER'S NAME Andrew Mueller		13b. MOTHER'S MAIDEN NAME Wilhelmia Franke		
14. NAME OF HUSBAND OR WIFE Selma Mueller			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		
17. INFORMANT'S SIGNATURE OR NAME Selma Mueller			18. ADDRESS 4056 Blaine Ave.				
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) Senility II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic cystitis + Prostatitis				INTERVAL BETWEEN ONSET AND DEATH 5 hours	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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) 94A		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR _____ H201				22. I hereby certify that I attended the deceased from April 4, 1949 , to May 7th , 19 49 , that I last saw the deceased alive on May 7th , 19 49 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above.	
23a. SIGNATURE C. W. Jung (Degree of title) _____			23b. ADDRESS 2278 S Jefferson			23c. DATE SIGNED 5-7-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May 9, 1949		24c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		24d. LOCATION (City, town, or county) (State) St. County, Mo.	
DATE REC'D BY LOCAL REG. MAY 8 1949		REGISTRAR'S SIGNATURE J. B. Lester		25. FUNERAL DIRECTOR'S SIGNATURE PASCHEDAG-HENKE		ADDRESS 2825 N. Grand B lvd	

(Licensed Embalmer's Statement on Reverse Side)

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

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 me

Student Embalmer No.

working under my personal supervision.

Signed

Guy W. Wilkinson

Signed

Student Embalmer

Licensed Embalmer No.

3575

P. O. Address

St. Louis, 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.