

FILED SEP 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34476

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2219

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>St. Louis</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lamay</u>		a. STATE <u>Missouri</u>		b. COUNTY <u> </u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mt. St. Rose Hosp</u>		Length of stay in lb <u>2 years</u>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward</u>				4. DATE OF DEATH		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
First <u>Edward</u>		Middle <u>J</u>		Last <u>Mueller</u>		Month <u>Sept</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 20, 1885</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Metal Worker (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Mueller</u>				14. MOTHER'S MAIDEN NAME <u>Stephanie Razion</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Mr. Jule E. Mueller, 4275 Farlin Avenue</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mild/old Myocarditis, chronic</u>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						3 months 3 years	
DUE TO (b) <u>Arteriosclerosis</u>							
DUE TO (c) <u>7221A</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Fulmonary tuberculosis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY		Hour <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>6/10/57</u> to <u> </u> and last saw <u>him</u> alive on <u>9/3/57</u> Death occurred at <u>8:15 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>John E. Deville, M.D.</u>				22b. ADDRESS <u>16 Hampton Village Plaza</u>		22c. DATE SIGNED <u>9/6/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>Sept 9 1957</u>		<u>New Picker Cemetery</u>		<u>St. Louis, Missouri</u>	
24. FUNERAL DIRECTOR <u>Math Hermann & Son, Inc., 2161 E. Fair</u>				25. DATE RECD. BY LOCAL REG. <u>9-6-57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Donohue</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health,
Welfare
Public
Service300
-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.....
Signature of Student Embalmer

Signed *Clement M. Quay*

Licensed Embalmer No... 39

P. O. Address *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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.