

pt. Health,
, & Welfare
S. Public
th Service

FILED NOV 21 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42383
STATE FILE NUMBER
10851
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

S. 300
av. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		c. CITY OR TOWN St Louis 9	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 30 Saint Louis Maternity		d. STREET ADDRESS 2141/2 4941a Pernod	
3. NAME OF DECEASED (Type or print) First Middle Last Mueller		4. DATE OF DEATH Month Day Year October 27 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 26 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St Louis Missouri
13a. FATHER'S NAME Richard David Mueller		13b. MOTHER'S MAIDEN NAME Willa Mae Grove	14. NAME OF HUSBAND OR WIFE ---
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---	17. INFORMANT Willa Mae Mueller Address Above
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>Congenital St. Louis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<u>754.4</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cholera</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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT 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>October 26 1957</u> to <u>October 27 1957</u> last saw her alive on <u>October 27 1957</u> Death occurred at <u>9:40 P M</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Marshall B. Gamm, M.D.</u> (Degree or title)		22b. ADDRESS <u>950 Francis Pl.</u>	22c. DATE SIGNED <u>11-6-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>11-30-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
24. FUNERAL DIRECTOR <u>Rowland Aker 404 Manchester</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>NOV 14 '57</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith MD</u> mjk

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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

Licensed Embalmer No.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.