

FILED NOV 19 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42385  
STATE FILE NUMBER  
Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10778**

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hosp.</b>		Length of stay in lb STREET ADDRESS <b>1143 Dover Pl.</b>	
3. NAME OF DECEASED (Type or print) First <b>LEONA</b> Middle <b>K.</b> Last <b>MUELLER</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>10</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 3, 1878</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>79</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Unknown Pfeiffer</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	
14. NAME OF HUSBAND OR WIFE <b>Albert G. Mueller</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, was or unknown) (If yes, give year or dates of service) <b>No None</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Albert G. Mueller 1143 Dover Pl.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart disease marked decompensation</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Diabetes mellitus</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>
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.) <b>260x</b>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <b>July 1957</b> to <b>4/10/57</b> and last saw her alive on <b>4/10/57</b> Death occurred at <b>4:00 P.</b> on the date stated above; and to the best of my knowledge, from the causes stated.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE <b>Joe Grant M.D.</b>		22b. ADDRESS <b>5574 S. Perry</b>	
22c. DATE SIGNED <b>11/11/57</b>		23. NAME OF CEMETERY OR CREMATORY <b>Park Lawn Cemetery</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Nov. 13, 1957</b>	
23c. LOCATION (City, town, or county) <b>St. Louis Co. Mo.</b>		24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway</b>	
25. DATE RECD. BY LOCAL REG. <b>NOV 12 '57</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>	

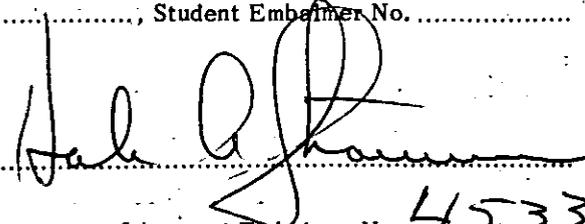
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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. 4533 .....

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.