

U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 25 1960

60-017172

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ 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, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D O A St. Louis City Hospital		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7627 Water St.
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Eddie Middle F. Last Mueller	4. DATE OF DEATH Month April Day 14 , Year 1960
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5. SEX Male	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 10-28-1895	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Unemployed	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U S A
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13a. FATHER'S NAME John C. Mueller	13b. MOTHER'S MAIDEN NAME Eva Erb	14. NAME OF HUSBAND OR WIFE -----
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-1	16. SOCIAL SECURITY NO. 498-09-1639	17. INFORMANT Otto Mueller 532 a Bates St.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH Unknown
IMMEDIATE CAUSE (a)	Arteriosclerotic heart disease	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	General Arteriosclerosis	
DUE TO (b)		420.0
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year

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
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21. I attended the deceased from Nov. 7, 1953 to Apr 14, 60 and last saw him alive on Apr 11, 60 Death occurred at 2:30 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>Raymond P. ...</i>	(Degree or title)	22b. ADDRESS 7712 Irving Ave	22c. DATE SIGNED 4/15/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-18-1960	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) Jefferson Bks. Mo.
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24. FUNERAL DIRECTOR C. Hoffmeister Mortuaries 7814 S. Broadway	ADDRESS	25. DATE RECD. BY LOCAL REG. APR 15 1960	26. REGISTRAR'S SIGNATURE <i>Loal Smith, M.D.</i> m 8 3
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John Shennie

Licensed Embalmer No. 419

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.