

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-020784

5012 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

FILED MAY 31 1962

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. Louis</u>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY		c. CITY OR TOWN <u>ST. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3458 OHIO</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3458 OHIO</u>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>Muehler</u> Last						4. DATE OF DEATH Month <u>MAY</u> Day <u>15</u> Year <u>1962</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-13-1890</u>		9. AGE (last birthday) <u>72</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED DRINK PRESS OPERATOR</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>AUSTRIA HUNGARY</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>			
13a. FATHER'S NAME <u>MATT Muehler</u>				13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				14. NAME OF HUSBAND OR WIFE <u>CHRISTINA Muehler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>CHRISTINA Muehler 3458 OHIO</u> Address					
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>Cerebral Vascular Hemorrhage</u> DUE TO (b) <u>A-V C V R Disease</u> DUE TO (c) <u>420.1</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Coronary Artery Disease</u>								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			
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.)							
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			
21. I attended the deceased from <u>1-5-62</u> to <u>5-15-62</u> and last saw him ^{HER} live on <u>5-14-62</u> Death occurred at <u>4 P. m</u> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>Charles A. Rester, MD</u>						22b. ADDRESS <u>3654 5 Grand</u>			22c. DATE SIGNED <u>5-17-62</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>MAY 19, 1962</u>		<u>RESURRECTION P.M.</u>		<u>ST. Louis Co Mo</u>					
24. FUNERAL DIRECTOR <u>Shenan Kuti 2906 Grand</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>MAY 17 1962</u>		26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u>			

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300 Rev. 4/59

1

2 22

3

4 0

5 1

6

7 2

8 2

9

10

11

12 90-0

13

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

90

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 *Lochly H. Hays*

Licensed Embalmer No. 4861

P. O. Address St. Louis 3, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.

Dr. C. Hunter
3654 S Grand
MO 4 5567
12-4 St. Louis.