

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-024980

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6313**

FILED JUL 2 1962

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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, Mo.</b>		c. CITY OR TOWN <b>St. Louis, Mo.</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) (DOA) HOSPITAL OR INSTITUTION <b>St. Anthonys H<sup>O</sup>spital</b>		d. STREET ADDRESS (If outside, give location) <b>5327 Robert</b>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HELEN DOBRNIC Mueller</b>			4. DATE OF DEATH Month Day Year <b>June 24 1962</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>5/7/1891</b>
9. AGE (last birthday) <b>71</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Yugoslavia</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>John Jakovac</b>	
13b. MOTHER'S MAIDEN NAME <b>Barbara -----</b>		14. NAME OF HUSBAND OR WIFE <b>Jacob</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Jacob Mueller</b>		Address <b>5327 Robert</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</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>420.0</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) <b>Bronchial Asthma. Pulmonary Emphysema.</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <b>Nov 1957</b> to <b>24 June 1962</b> and last saw her alive on <b>13 June 62</b> Death occurred at <b>3:50 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Raymond V. Martin MD</b>		22b. ADDRESS <b>5203 Chryseum St.</b>	22c. DATE SIGNED <b>6-20-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
24. FUNERAL DIRECTOR <b>John L. Ziegenhein &amp; Sons 7027 Gravois</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 26 1962</b>	26. REGISTRAR'S SIGNATURE <b>Roald Smith M.D.</b>

**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 G. P. Kedwell

Licensed Embalmer No. 3877

P. O. Address 7027 Gravois

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.