

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

-62-024982

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. \_\_\_\_\_ Registrar's No. 6066

**FILED JUN 2 1962**

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

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 <u>12 hrs.</u>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ill.</u> b. COUNTY <u>Clinton</u>		c. CITY OR TOWN <u>Carlyle</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>											
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>none</u>			(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>FREDERICK</u> Last <u>MUELLER</u>			4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1962</u>			5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-41</u>		9. AGE (last birthday) <u>20</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>			11. BIRTHPLACE (City and state or country) <u>Carlyle, Ill.</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			13a. FATHER'S NAME <u>Eugene L. Mueller</u>			13b. MOTHER'S MAIDEN NAME <u>Juanita Higgins</u>			14. NAME OF HUSBAND OR WIFE <u>none</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes 9-61 to 10-61</u>			16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Eugene L. Mueller, Carlyle, Ill.</u>			Address			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). IMMEDIATE CAUSE (a) <u>Chronic Myelogenous Leukemia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>Chronic Myelogenous Leukemia</u>			DUE TO (b)			DUE TO (c)			<u>2041</u>			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					
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 _____ 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 <u>Carlyle, Ill.</u>			COUNTY			STATE									
21. I attended the deceased from <u>6-15-62</u> to <u>6-16-62</u> and last saw her alive on <u>6-16-62</u> Death occurred at <u>7:30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.												22a. SIGNATURE <u>W.B. - Hedney M.D.</u> (Degree or title)			22b. ADDRESS <u>St. John's Hospital</u>			22c. DATE SIGNED <u>6-16-62</u>		
23b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6-19-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>			23d. LOCATION (City, town, or county) <u>Carlyle, Ill.</u>			(State)										
24. FUNERAL DIRECTOR <u>Paul Frerker, Carlyle, Ill.</u> ADDRESS					25. DATE RECD. BY LOCAL REG. <u>JUN 19 1962</u>			26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>												

USE BLACK INK OR TYPEWRITER RIBBON

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*OK*  
*Kelant Taylor*  
*Coroner 6-19-62*

**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 John J. Kassly

Licensed Embalmer No. 5039

P. O. Address E. St. Louis, 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.