

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-034541

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2341

STATE FILE NUMBER

FILED AUG 23 1963

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lemay		Length of stay in 1b 4 MOB	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Maryridge Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4215 Louisiana Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First OLLIE Middle M. Last MUELLER			4. DATE OF DEATH Month July Day 21 Year 1963		
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/6/1885	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY domestic	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Herman Dicke		13b. MOTHER'S MAIDEN NAME Ella Bryant		14. NAME OF HUSBAND OR WIFE Charles A. Mueller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No		16. SOCIAL SECURITY NO.	17. INFORMANT Address Mr. Clarence E. Mueller, 9708 Graystone (19		

18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 hrs
Conditions, if any, which gave rise to above cause (e), stating the underlying cause last.) DUE TO (b) arterio sclerotic heart disease		?
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertension and C. V. A 5/1/63		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.) Home
20c. TIME OF INJURY Hour 5:35 P. 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.) St. Louis	20f. CITY, TOWN, OR LOCATION COUNTY STATE St. Louis Mo.
21. I attended the deceased from 3/23/63 to 7/21/63 and last saw her/him alive on July 19, 1963 Death occurred at 5:35 P. m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE Marie Starbuck MD (Degree or title)	22b. ADDRESS 512 Dow Place	22c. DATE SIGNED 7/22/63
--	--------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 7/24/63	23c. NAME OF CEMETERY OR CREMATORY Laurel Hills Mem. Gardens	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
--	-----------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS BEIDERWIEDEN F.H., INC., 1936 St. Louis Ave.	25. DATE RECD. BY LOCAL REG. 7-23-63	26. REGISTRAR'S SIGNATURE J. H. Murphy MD
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59

14000

2 8/59

3

4 1

5 2

6

7 0

8 2

94200

10

11

12 86-0

13

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

86

PR 25885

Dr. Max Starkloff
512 Dover
before Noon Monday

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 Homer W. Dritz

Licensed Embalmer No. 3882

P. O. Address St. Louis

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.

JUN 1904