

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9072 63-037868

DO NOT WRITE ON THIS STUB

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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

FILED SEP 19 1963	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>St Louis</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u> Length of stay in lb <u>11 Days</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Illinois</u> COUNTY <u>MADISON</u></p> <p>c. CITY OR TOWN <u>Collinsville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>616 W. CLAY</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print) First Middle Last <u>BERNHARDT G. MUELLER</u></p>	
<p>4. DATE OF DEATH <u>September 9 1963</u></p>	
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>9-16-1882</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u>	9b. KIND OF BUSINESS OR INDUSTRY <u>Barber</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Barber</u>
11. BIRTHPLACE (City and state or country) <u>Collinsville, Ill</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
13a. FATHER'S NAME <u>CONRAD MUELLER</u>	13b. MOTHER'S MAIDEN NAME <u>MARIE BRASSE</u>
14. NAME OF HUSBAND OR WIFE <u>OLINDA</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. <u>163x</u>
17. INFORMANT <u>Elmer Mueller</u>	Address <u>St. Louis Mo</u>
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Epidermoid carcinoma lung with metastases</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____</p> <p>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</p> <p>INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u></p>	
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. _____	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>3/5/63</u> to <u>9/9/63</u> and last saw him alive on <u>9/9/63</u> . Death occurred at <u>8:10 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>E. D. Vermillion, M.D.</u>	22b. ADDRESS <u>M.D. BARNES HOSPITAL</u>
22c. DATE SIGNED <u>9/9/63</u>	
23a. CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9-11-63</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Lutheran</u>	23d. LOCATION (City, town, or county) (State) <u>Collinsville Ill</u>
24. FUNERAL DIRECTOR <u>HERR</u>	25. DATE RECD. BY LOCAL REG. <u>SEP 10 1963</u>
26. REGISTRAR'S SIGNATURE <u>Roald Smith, M.D.</u>	

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

Frank Proloff

Licensed Embalmer No.

4356

P. O. Address

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.