

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County _____

Township _____

Registration District No. 791File No. 8393

or Village _____

Primary Registration District No. 1003Registered No. 2290City St. Louis Mo. (NO. 3680) Folsom Ave. St. 13 Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Helen Gene Mueller

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED Single WIDOWED OR DIVORCED
(Write the word)DATE OF DEATH Feb. 25, 1917
(Month) (Day) (Year)DATE OF BIRTH Feb. 17, 1917
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Feb. 17, 1917, to Feb. 25, 1917, that I last saw her alive on Feb. 24th, 1917, and that death occurred, on the date stated above, at 6⁵⁵ A.M.AGE _____ yrs. _____ mos. 8 ds. If LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work None[Infection]
Pneumonia

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) St. Louis Mo.(Duration) _____ yrs. _____ mos. 2 ds.NAME OF FATHER Walter MuellerContributory Congenital Debility -BIRTHPLACE OF FATHER (City or town, State or foreign country) St. Louis Mo.(Duration) _____ yrs. _____ mos. 8 ds.MAIDEN NAME OF MOTHER Geneva Beckstegil(Signed) Arthur H. de Marsey M. D.BIRTHPLACE OF MOTHER (City or town, State or foreign country) Belleville Ill.2/25, 1917 (Address) 4046 N. Grand Av.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

(Informant) Walter Mueller

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

(ADDRESS) 3015 Virginia St. St. Louis Mo.

Where was disease contracted if not at place of death? _____

Filed 1917 May 6 Starkloff

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Belleville Ill. DATE OF BURIAL Feb 26, 1917UNDERTAKER Edwin Gardner ADDRESS Belleville Ill.

REGISTRAR

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

1 PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County
 Township
 or
 Village
 or
 City *St. Louis*

REGISTRARS SHALL NOT RECEIVE
 A FEE FOR CERTIFICATES UNTIL THEY
 ARE COMPLETED AS PRESCRIBED BY
 LAW

Registration District No. *791* File No.

Primary Registration District No. *1003* Registered No. *2290*

(NO. St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Heber Gen Mueller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *S*

6 DATE OF BIRTH (Month) (Day) 1 (Year)

7 AGE (yrs) (mos) (ds) If LESS than 1 day hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country)

10 NAME OF FATHER
 11 BIRTHPLACE OF FATHER (City or town, State or foreign country)
 12 MAIDEN NAME OF MOTHER
 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) (Address)

15 Filed *2/26* 191*7* *Mar. 6 Starkloff* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Feb - 25* 191*7*
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 191..... to 191..... that I last saw h..... alive on 191..... and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH was as follows:
(Infection)
Broncho-Pneumonia 91

(Duration) yrs. mos. ds.
 CONTRIBUTORY *Congenital Debility*
 (Secondary) (Duration) yrs. mos. ds.
 (Signature) *Arthur H. de Masy* M. D.
125 191*7* (Address) *4046 W. Grand av.*

*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
 At place of death yrs. mos. ds. In the State yrs. mos. ds.
 Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191.....
 20 UNDERTAKER ADDRESS

Original file, date *Feb 2* 191*7* All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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