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

Do not use this space.

6 [illegible]

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 1225

City St. Louis Mo. (No. 2714 Potomac St. ..... Ward)

2. FULL NAME Jacob Mueller

(a) Residence (Usual place of abode) No. 2714 Potomac St., 24 Ward. ..... (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 11-1862

7. AGE: 64 YEARS, 4 MONTHS, 21 DAYS. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Foreman
(b) General nature of industry, business, or establishment in which employed (or employer): Chase Bag Co.
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ill.

PARENTS
10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): "
12. MAIDEN NAME OF MOTHER: "
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): "

14. INFORMANT: Minnie Mueller
(Address) 2714 Potomac St.

15. FILED FEB -3 1927 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 2 - 1927.

17. I HEREBY CERTIFY, That I attended deceased from April 22, 1922, to Feb. 2, 1927, that I last saw h[illegible] alive on Feb. 2, 1927, and that death occurred, on the date stated above, at 10:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
9013
(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Acute Cardiac Dilatation
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? I do not know
DID AN OPERATION PRECEDE DEATH? no DATE OF none
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Laboratory + X Ray.

2/2 (Signed) [signature], M. D
1927 (Address) 3511 Lucas Ave

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Park Lawn Cem.
DATE OF BURIAL: Feb. 5 - 1927.

20. UNDERTAKER: Ziegenhain Bros. 2623
ADDRESS: Cherokee

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

[illegible] WITH UNFADING INK—THIS IS A PERMANENT RECORD