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

Do not use this space.

16563

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. 4665

Township ..... Primary Registration District No. ..... Registered No. .....

City ..... (No. 4233 N. Broadway St. ..... Ward)

2. FULL NAME Mary Mueller

(a) Residence. No. 4233 N. Broadway (Usual place of abode) 9 Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred X yrs. 2 mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-4-1865

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	63	9	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

PARENTS

10. NAME OF FATHER Fred Ortlett

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Mary Arnest

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Mrs. Hilda Dickman (Address) 4233 N. Broadway

15. FILED APR 22 1929 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 21 1929

17. I HEREBY CERTIFY, That I attended deceased from April 13th, 1929, to April 20th, 1929 that I last saw her alive on April 20th, 1929, and that death occurred, on the date stated above, at 8.30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Parenchymatous Nephritis

131 (duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) S. Elfeck, M. D.

April 22 1929 (Address) 4185 W. Kinsseunt av

*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	DATE OF BURIAL
Friedens Cem.	4/23 1929
20. UNDERTAKER	**ADDRESS**
W. A. Stock Und Co	2117 E. Grand

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.