

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

Do not use this space.

19664

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **Louis** (No. **City, Republic**)

File No.

Registered No. **5271**

St. Ward)

2. FULL NAME

(a) Residence. No. **2018 Quail Lodge St.** **24** Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **30** yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **widow**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **March 1853**

7. AGE YEARS **76** MONTHS **2** DAYS **19** IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work **Labourer** (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer **Adolph Busch, Germany**

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

10. NAME OF FATHER **Barthold Mueller**

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

12. MAIDEN NAME OF MOTHER **Unknown**

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

14. INFORMANT **Ed. Russell** (Address) **1017 W. 1st St. St. Louis, Mo.**

15. FILED **MAY 11 1929** **Max C. Stanley** REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 10 1929**

17. I HEREBY CERTIFY That I attended deceased from **May 8 1929** to **May 10 1929** that I last saw him alive on **May 10 1929** and that death occurred, on the date stated above, at **7:30 PM**

THE CAUSE OF DEATH* WAS AS FOLLOWS: **Chronic myocarditis, Atrial fibrillation**

CONTRIBUTORY (SECONDARY) **NO**

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....

19. WHAT TEST CONFIRMED DIAGNOSIS? **clinical**

(Signed) **Edward Welby, M. D.** 5/10/29 (Address) **City, Republic**

*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 **Crematory** DATE OF BURIAL **May 11 1929**

20. UNDERTAKER **W. J. Roberts** ADDRESS **1905 So. Grand Blvd.**

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.

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

10 10 10 237

Müller