

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

Do not use this space.

26617

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis, Mo.*

Registration District No. *791*
1003
Primary Registration District No. *3234 & Delore*

File No.....
Registered No. *7887*
St. Ward)

2. FULL NAME

Johanna E. Mueller
(a) Residence No. *3234 & Delore* St., *15* Ward.
(Usual place of abode)

(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 <i>Female</i> | 4. COLOR OR RACE <i>White</i> | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>married</i> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF | | |
| 6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Sept. 24 - 1869</i> | | |
| 7. AGE | YEARS | MONTHS |
| <i>59</i> | <i>10</i> | <i>4</i> |
| 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>House Wife</i> (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) <i>St. Louis Mo.</i> | | |
| PARENTS | 10. NAME OF FATHER <i>Unknown</i> | |
| | 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis Mo.</i> | |
| | 12. MAIDEN NAME OF MOTHER <i>Madeline Brockmeyer</i> | |
| | 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis Mo.</i> | |

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 28 - 1929*

17. I HEREBY CERTIFY, That I attended deceased from *April* 1929 to *July 28* 1929 that I last saw her alive on *July 27* 1929, and that death occurred, on the date stated above, at *11:20* a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of uterus - metastasis
46C (duration) *2* yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED *Not at place of death*
DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF _____
WAS THERE AN AUTOPSY? *No*
WHAT TEST CONFIRMED DIAGNOSIS *Clinical*
(Signed) *M. J. Stewart* M. D.
729 1929 (Address) *2800 - 9 Payne*

*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 <i>Concordia Cem.</i> | DATE OF BURIAL <i>7-31-1929</i> |
| 20. UNDERTAKER <i>Ziegenheim Bros. 2623 1/2 Cherokee St.</i> | ADDRESS |

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.

14. INFORMANT *Philip J. Mueller*
(Address) *5234 & Delore St.*

15. FILED *31 1929* *May C. Stanley* REGISTRAR

