

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

Do not use this space.

16284

1. PLACE OF DEATH

County

Registration District No. **791**

Township

Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital**)

File No.

Registered No. **4776**

St.

Ward)

2. FULL NAME Pauline Mueller

(a) Residence, No. 1421 Logan St. 21 Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 8 - 1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 2 12

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work (m) 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 16

10. NAME OF FATHER Joseph Mueller

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

12. MAIDEN NAME OF MOTHER unknown

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

14. Informant Hospital information
Grace
(Address) City Hospital

15. FILED APR 21 1931 W. W. Starnes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 20 1931

17. I HEREBY CERTIFY, That I attended deceased from April 10th 1931, to April 20 1931, that I last saw her alive on April 20 1931, and that death occurred, on the date stated above, at 1145 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
931
Chr. Myocarditis
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 931
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 931
IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH No DATE OF

20. WAS THERE AN AUTOPSY No

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) Ernest Johnson, M. D.
420 (Address) City Hospital

*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 Calvary Cem. DATE OF BURIAL Apr 22 1931

20. UNDERTAKER E. J. Schmu ADDRESS 3125 Lafayette

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.

