

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

Do not use this space.

3261

**1. PLACE OF DEATH**

County.....

Registration District No. *1791*

Township.....

Primary Registration District No. *10033*

City *St. Louis*

(No. *Lutheran Hospital*)

File No. ....

Registered No. *1035*

St. .... Ward)

**2. FULL NAME** *William F. Mueller*

(a) Residence, No. *RR #8 Box 11*  
(Usual place of abode)

St. *24* Ward. *Jefferson 1316, Mo*

(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>Male</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 <i>Emma Mueller</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Aug. 18, 1902</i>		
7. AGE	YEARS	MONTHS
	<i>29</i>	<i>5</i>
		<i>13</i>
		If LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Gardener</i>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>Truck</i>	<i>5</i>
	10. Date deceased last worked at this occupation (month and year) .....	11. Total time (years) spent in this occupation .....
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis Co. Mo</i>		
MOTHER	13. NAME <i>Fred Mueller</i>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis Co. Mo</i>	
	15. MAIDEN NAME <i>Anna Mueller</i>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis Co. Mo</i>	
17. INFORMANT <i>Mrs Emma Mueller</i> (ADDRESS) <i>RR #8 Box 11</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>St. Kinley's Cath. Ch.</i> DATE <i>2/2/32</i>		
19. UNDERTAKER <i>C. J. H.meister N. &amp; L. Co.</i> (ADDRESS) <i>107 E. 1st Broadway</i>		
20. FILED <i>FFR - 1 1932</i> REGISTRAR <i>W. C. J. W. H. M. H.</i>		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 31, 1932*

22. I HEREBY CERTIFY That I attended deceased from *Jan 30, 1932* to *Jan 31, 1932*

I last saw him alive on *Jan 30, 1932*. Death is said to have occurred on the date stated above, at *12:11 A.M.*

The principal cause of death and related causes of importance were as follows:

*Compound comminuted fracture of skull, frontal bone*

*Struck on head with grindstone while sharpening*

Other contributory causes of importance: *Accident, Fool*

Name of operation *Crematory* Date of *Jan 30*

What was confirmed diagnosis? *Asphyxiation* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? *no accident* of injury *Jan 30, 1932*

Where did injury occur? *at home*  
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.  
*in home*

Manner of injury *sharpening tool on grindstone*

Nature of injury *Compound fract skull*

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify *The H. Hanner*, M. D.  
(Signed) *The H. Hanner*  
(Address) *3657 Webster*

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.

3651 Robinson  
2411 42  
49 20