

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.

MAY 13 1935

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis Mo.** (No. **2917 Eads av.**)..... St. Ward)

15067

File No.....
Registered No. **3952**..... St. Ward)

2. FULL NAME

Anna M. Mueller
(a) Residence, No. **2917 Eads av.** St. **17** Ward. (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 **female** | 4. COLOR OR RACE **white** | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **widow**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Sept. 24-1856**
7. AGE YEARS **78** MONTHS **7** DAYS **4** If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **mlr**
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **mlr**
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) **Germany**

13. NAME **Norden**
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**
15. MAIDEN NAME **mlk.**
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**
17. INFORMANT **Mr Carl Mueller** (ADDRESS) **2917 Eads av.**
18. BURIAL, CREMATION, OR REMOVAL PLACE **Walhalla Cem.** DATE **May 1** 19**35**
19. UNDERTAKER **E. J. Schmur** (ADDRESS) **3125 Lafayette av.**
20. FILED **APR 30 1935** **St. Louis** Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **April 28** 19**35**
22. I HEREBY CERTIFY, That I attended deceased from **3-19** 19**35** to **4-28** 19**35**
I last saw her alive on **4-28** 19**35** Death is said to have occurred on the date stated above, at **3 p. m.**
The principal cause of death and related causes of importance were as follows:
myocardial thromb Date of onset
930
Other contributory causes of importance:
intermittent
Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury..... 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury.....
Nature of injury.....
24. Was disease or injury in any way related to occupation of deceased? **no**
If so, specify **B. Shaver** (Signed) **B. Shaver**, M. D.
(Address) **1574 5th Jefferson**

