

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

Do not use this space.

NOV 2 1935

791

31345

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City *St. Louis* (No. *Josephine Hosp.*) St. (Ward)

File No.
Registered No. **8182**

2. FULL NAME

(a) Residence, No. *4747 Alana* St. *2* 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 *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *widowed*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Feb 28 - 1891*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
44 6 29

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Gloman*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *broker*
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) *St. Louis Missouri*

13. NAME *Fred C Mueller*

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

15. MAIDEN NAME *Anna Schuel*

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

17. INFORMANT (ADDRESS) *Anna M Mueller 4747 Alana*

18. BURIAL, CREMATION, OR REMOVAL PLACE *St. Joseph's Bk* DATE *9/30/35*

19. UNDERTAKER (ADDRESS) *St. J. Ziegenhauer 1720*

20. FILED *SEP 28 1935* Registrar. *J. Bredeck*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 28 1935*

22. I HEREBY CERTIFY, That I attended deceased from *9-16-1935* to *9-28-1935*

I last saw him alive on *9-22-1935* Death is said to have occurred on the date stated above, at *7 A* m.

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

myelocytic Leukemia Date of onset *9-15-35*

Other contributory causes of importance *Strep - scar throat* *9-15-35*

Name of operation *none* Date of
What test confirmed diagnosis? *Lab* Was there an autopsy? *no*

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

(Signed) *Louis F. Murray*, M. D.
(Address) *1931 - 6 - 6 St. Bx.*

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.

WHILE FEARLET, WITH UNFADING INK—THIS IS A PERMANENT RECORD

