

NOV 4 1936

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

Do not use this space.

39480

1. PLACE OF DEATH

County.....
Township.....
City..... (No.)

Registration District No. **791**
Primary Registration District No. **1003**
412 Desoto Ave.,

File No. **10521**
Registered No.
St. Ward)

2. FULL NAME **George E. Mueller,**(a) Residence, No. **412 Desoto Ave.** St. **9** 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

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married.**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Oct 18**, 19**36**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Elizabeth Mueller**22. I HEREBY CERTIFY, That I attended deceased from **Aug 28**, 19**36**, to **Oct 18**, 19**36**6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **12/28/1878**I last saw **him** alive on **Oct 12**, 19**36**. Death is said7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
57 **9** **20**to have occurred on the date stated above, at **1040 P.**

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

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Common Labor**Date of onset **Aug 1**

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Abscess of Peritoid & sublingual glands (R), whether tubercular & malignant unknown, as patient refused operation.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

Other contributory causes of importance:

1158212. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Mo.**13. NAME **Valentine Mueller,**

Name of operation..... Date of.....

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

What test confirmed diagnosis?..... Was there an autopsy?.....

15. MAIDEN NAME **Unknown**

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

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

Where did injury occur?..... (Specify city or town, county, and State)

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

17. INFORMANT **Elizabeth Mueller,** (ADDRESS) **412 Desoto Ave.**

Manner of injury.....

Nature of injury.....

18. BURIAL, CREMATION, OR REMOVAL

PLACE **Calvary** DATE **10/21/36** 19

24. Was disease or injury in any way related to occupation of deceased?.....

19. UNDERTAKER **V. A. Stock Und. Co.** (ADDRESS) **2117 E. Grand Blvd.**

If so, specify

(Signed) **Arthur P. Smith**, M. D.20. FILED **OCT 20 1936** **J. P. Bredeck** Registrar.(Address) **4500 Clarence**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Dr Smith

5035 70 1/2 Ave
