

REC'D FEB 10 1939

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

791
1003

733

Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No.
(b) Township Primary Registration District No.
(c) City St. Louis (d) Street No. City Hospital No. 1 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

D. 15146

460

Fred Mueller

2. PRINT FULL NAME

(a) Residence, No. 1917 Hickory St. 22 (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 7, 1878

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
60 6 14

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Retired chemist
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) Philadelphia Pennsylvania

13. NAME Johh Mueller

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

15. MAIDEN NAME unknown

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

17. INFORMANT Hosp. Info M. Kent (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Sunset Burial Park DATE 1/24/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Bensiek-Niehaus
14 31 Union

20. FILED JAN 24 1939

J. D. Bensiek
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/21/39 19

22. I HEREBY CERTIFY That I attended deceased from 1/16/39 to 1/21/39, 19

I last saw him alive on 1/21/39 19. Death is said to have occurred on the date stated above, at 11.15 p
The principal cause of death and related causes of importance were as follows:

Synthetic aortic insufficiency with failure

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....
What test confirmed diagnosis?..... 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) E. D. Lusk M. D.
(Address) City Hospital No. 1

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....
working under my personal supervision.

Registered Apprentice No.....

Signed..... *Frank H. Kiehn*

Licensed Embalmer No. *2951*

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.