

REC'D JUN 8 1939

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

17630
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Kaw Primary Registration District No. 1002 Registered No. 2032
 (c) City Kansas City, Mo. (d) Street No. 6607 E. 15th Terrace 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.

2. PRINT FULL NAME August Mueller

(a) Residence, No. 6601 East 15th Terrace St. (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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Augusta Mueller</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Jan. 15, 1863</u>		
7. AGE YEARS <u>76</u>	MONTHS <u>3</u>	DAYS <u>29</u>
If LESS than 1 day, hrs. or min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Cabinet</u>	11. Total time (years) spent in this occupation
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>Maker</u>	
	10. Date deceased last worked at this occupation (month and year)	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Chicago Illinois</u>		
FATHER	13. NAME <u>August Mueller</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>	
MOTHER	15. MAIDEN NAME <u>Clara Wernich</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>	
17. INFORMANT <u>Mrs. F. W. Argo</u> (ADDRESS) <u>6607 E 15th Terrace</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Floral Hills</u> DATE <u>May 16-39</u> 19 <u>39</u>		
19. FUNERAL DIRECTOR (NAME) <u>C.H. Blackman & Son, Inc.</u> (ADDRESS) <u>2825 Indep. Blvd. K.C. Mo.</u>		
20. FILED <u>May 15 1939 M. M. Crome</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 14, 1939 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 25, 1939, to May 14, 1939.
 I last saw him alive on May 5, 1939. Death is said to have occurred on the date stated above, at 3:15 m. AM
 The principal cause of death and related causes of importance were as follows:
Chronic myocarditis
Arteritis
93C

Date of onset 1939 Nov. 38

Other contributory causes of importance:

Name of operation None Date of.....
 What test confirmed diagnosis? Microscopic study 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) Harry C. Lem, M. D.
 (Address) 1103 Mount

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.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....
Licensed Embalmer No.....
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.