

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

34203

8741

Registrar's No.

Registration District No.

791

Primary Registration District No.

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Josephine Heitkamp Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day
 (Specify whether
 In this community Birth
 years, months or days)

3. (a) PRINT FULL NAME George S. Muhr 6008. (b) If veteran, name war None 3. (c) Social Security No. 489-03-51914. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive None years7. Birth date of deceased November 10, 1912
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
26 11 0 hr. min.9. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)10. Usual occupation Unemployed

11. Industry or business

12. Name John Muhr
13. Birthplace Austria
(City, town, or county) (State or foreign country)14. Maiden name Anna Steiner
15. Birthplace Austria
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Mr John Muhr(b) Address 8520 Gilmore Ave17. (a) Burial (b) Date thereof 10-14-39
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Friedens Cemetery18. (a) Signature of funeral director Math Hermann & Son(b) Address 2161 East Fair Ave19. (a) OCT 13 1939 (b) J. B. Badick
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 8520 Gilmore Ave
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 10 year 1939
hour 9 minute 20 P. M.21. I hereby certify that I attended the deceased from June 1939
to Oct. 10, 1939.that I last saw him alive on Oct 10, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death

acute pulmonary edema 7 hrs
following tonsillectomy.
 Due to Rheumatic Mitral Stenosis
Non-diphtheritic caused by
chronic tonsillitis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

On While at work? (Specify type of place) (e) Means of injury _____

23. Signature S. Dworkin M.D. (M. D. or other) M.D.
Address 1700 1/2 Tower Grove Date signed 10-12-39

WHITE PRINTING—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *Thomas Hampton*

Licensed Embalmer No. *2967*

P. O. Address *St. Louis, Mo*

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.