

Registration District No. **1003** 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:
1925A. College.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community 55 Years.

NOV 13 1939

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. 1925A. College.
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? 55 years.

3. (a) PRINT FULL NAME William Mueller.

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male. 5. Color or race White. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Anna Winkelmann Mueller. 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased July 4, 1855.
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>3</u>	<u>15</u>	hr. _____ min. _____

9. Birthplace Germany.
(City, town, or county) (State or foreign country)

10. Usual occupation Shoe Business.

11. Industry or business 6

12. Name Unknown.

18. Birthplace Germany.
(City, town, or county) (State or foreign country)

14. Maiden name Unknown.

15. Birthplace Germany.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Anna Mueller

(b) Address 1925 College ave

17. (a) Burial. (b) Date thereof Oct. 23, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery.

18. (a) Signature of funeral director Stroot Carroll

(b) Address 4600 Natural Bridge.

19. (a) OCT 20 1939 (b) J. F. Brudick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH Month Oct day 19
 year 1939 hour 5 minute 45A M.

21. I hereby certify that I attended the deceased from Oct 1 - 29
 1939, to Oct 19, 1939
 that I last saw him alive on Oct 19
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Chronic Myocarditis 1933
 Due to _____

Due to Chronic Myocarditis 1933
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

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? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature F. J. Mueller M.D. (M. D. or other)
 Address 4114 W. Missouri Date signed 10/24/39

Duration _____
 Physician _____
 Underline the cause to which death should be charged statistically.

WRITE PLAINLY—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.....

Frank H. Street

Licensed Embalmer No. 2265

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.