

DEC 11 1939

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

39016
Do not use this space.

1. PLACE OF DEATH
 (a) County Buchanan Registration District No. 35
 (b) Township St. Joseph Primary Registration District No. 1002 Registered No. 1148
 (c) City St. Joseph (d) Street No. Missouri Methodist Hospital 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 59 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Anna Alvina Mueller
 (a) Residence, No. _____ St. St. Joseph, Missouri, Route #6
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 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 Fred J. Mueller

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 27, 1880

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
59 7 9

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

FATHER 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Joseph, Missouri
 13. NAME John Ackerman
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown, Unknown

MOTHER 15. MAIDEN NAME Barbara Unknown,
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown, Missouri

17. INFORMANT Fred J. Mueller
 (ADDRESS) St. Joseph, Missouri, Route #6

18. BURIAL CREMATION, OR REMOVAL St. Joseph, Missouri
 PLACE St. Auburn Cemetery DATE November 8, 1939

19. FUNERAL DIRECTOR (NAME) Walter Meindorfer
 (ADDRESS) 1302 Faraon St., St. Joseph, Missouri

20. FILED Nov 8 1939 A. J. Nuttlebush
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) November 6, 1939

22. I HEREBY CERTIFY That I attended deceased from July 17, 1939 to Nov. 6, 1939
 Most saw h. or alive on Nov. 5, 1939 Death is said to have occurred on the date stated above, at 1 p.m.
 The principal cause of death and related causes of importance were as follows:
Embolism - sudden death
Pulmonary
 Date of onset 5/9

Other contributory causes of importance:
Diabetes Mellitus
Gangrene left foot
 Unknown Oct 20, 1939

Name of operation Amputation left leg Date of Nov. 1, 1939
 What test confirmed diagnosis? clinical 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) Dr. Grant, M.D., M. D.
 (Address) 6207 King Hill, St. Joseph

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD
 MARGIN RESERVED FOR BINDING
 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, ~~W. H. Kelly~~.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....



Licensed Embalmer No. ~~No.~~ 3946

P. O. Address St. Joseph, Missouri.

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.