

Registration District No. 124

Primary Registration District No. 3009

Registrar's No. 37

1. PLACE OF DEATH:

(a) County Cape Girardeau **JUN FEB 12 1940**
 (b) City or town _____
 (c) Name of hospital or institution: Southsax Mo. Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 11 days
 years, months or days _____

3. (a) PRINT FULL NAME Christian G. 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 Widowed
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Oct. 24, 1848
 (Month) (Day) (Year)

8. AGE: Years 91 Months 2 Days 28 If less than one day hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name Gottlob Mueller
 18. Birthplace Germany (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Germany (State or foreign country)

16. (a) Informant's own signature Mrs Paul B. Capps
 (b) Address Frohna, Mo.

17. (a) Altenburg, Burial (b) Date thereof 1-24-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Altenburg, Mo.

18. (a) Signature of funeral director Wm. J. Schmitt

(b) Address Perryville, Mo.

19. (a) 1-21-40 (b) J. M. Thompson
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 21st
 year 1940 hour 9⁰⁰ minute 2: A. M.

21. I hereby certify that I attended the deceased from 1/10/40
 _____, 19____, to 1-21/40, 19____;
 that I last saw him alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death fracture of right femur Duration 1/10/40

Due to fall - hypostatic pneumonia 1/10/40

Due to age and position occupied while treated.

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____
 186 W

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) accident

(b) Date of occurrence 1/10/40

(c) Where did injury occur Frohna, Mo.
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at home (Specify type of place)

While at work? no (a) Means of injury slipped & fell

23. Signature G. P. Schultz (M. D. or other)
 Address Cape Girardeau, Mo. Date signed 1/21/40

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 Edward C. Young

Licensed Embalmer No. 12138

P. O. Address. Permyville 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.