

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 hrs. 40 mins.
(Specify whether

In this community 2 hrs. 40 mins.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis 23
(If outside city or town limits, write "RURAL")

(d) Street No. 2340 Park Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Baby Muehlenbeck 451

3. (b) If veteran, name war X

3. (c) Social Security No. Unknown

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

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive None years

7. Birth date of deceased March 23, 1940
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23, year 1940 hour 10:50 minute _____ P. M.

21. I hereby certify that I attended the deceased from March 23, 1940, to March 23, 1940, that I last saw him alive on March 23, 1940, and that death occurred on the date and hour stated above.

8. AGE: Years _____ Months _____ Days _____ If less than one day 2 hr. 40 min.

Immediate Cause of death Premature

Due to _____

Due to _____

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

Other conditions 151
(Include pregnancy within 3 months of death)

10. Usual occupation Nil.

11. Industry or business Nil.

Major findings: Of operations _____

Of autopsy _____

MOTHER, FATHER { 12. Name Kenneth Muehlenbeck

{ 13. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

{ 14. Maiden name Charlotte Spueres

{ 15. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant _____

(b) Address City Hospital, #1

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? _____

17. (a) Cremation (b) Date thereof 4 26 - 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City crematory

While at work? _____ (Specify type of place)

(e) Means of Injury _____

18. (a) Signature of funeral director W. J. White

(b) Address City Hospital, #1

23. Signature John F. Flynn (M. D. or other) _____

Address 1515 Lafayette Date 3/25/40

19. (a) _____ (b) _____
(Date received local registrar)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.