

Registration District No. **791**

Primary Registration District No. **1003**

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: **Enroute City 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 _____
years, months or days

3. (a) PRINT FULL NAME **Peter Robert Mueller**

3. (b) If veteran, name war **No.** 3. (c) Social Security No. **488-12-9912**

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

6. (b) Name of husband or wife **Louisa Jane** 6. (c) Age of husband or wife if alive **56** years

7. Birth date of deceased **Dec. 13 1871**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 10 28 hr. min.

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

10. Usual occupation **Machinist**

11. Industry or business _____

12. Name **Peter Mueller**

13. Birthplace **Switzerland**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

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

16. (a) Informant **Louisa Jane Mueller**

(b) Address **4155 McPherson Ave.**

17. (a) **Burial** (b) Date thereof **11/14/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St. Marcus Cem.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Ave.**

19. (a) **Nov 13 1940** (b) *J. E. Braddock*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** **19**
(If outside city or town limits, write "RURAL")
(d) Street No. **4155 McPherson**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

no attending **MEDICAL CERTIFICATION** physician

20. DATE OF DEATH: Month **November** **11th**
year **1940** hour **6** minute **02 P.M.**

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Sclerosis.** *Duration*

Due to _____

Due to _____

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) (b) Means of injury **5**

23. Signature *Alfred J. Perry* (M. D. or other)

Address *Regulatory Bureau* Date signed **11/13/40**

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

MOTHER FATHER

DECEASED DEC 11 1940

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

J. J. Sullivan

Licensed Embalmer No. *1122*

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, fact should be so stated above.