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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8005

Registration District No. 257 Primary Registration District No. 5998 Registrar's No. 32

1. PLACE OF DEATH:

(a) County ST. CHARLES [illegible]

(b) ~~City or town~~ ST. CHARLES, MISSOURI
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: EMMAUS HOME 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution INSTITUTION (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. CHARLES.

(c) City or town ST. CHARLES 92
(If outside city or town limits, write "RURAL") 0

(d) Street No. — 0
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME JOSEPHINE MUELLER

3. (b) If veteran, name war NIL

3. (c) Social Security No. NIL

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife AUGUST MUELLER

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased SEPTEMBER 14, 1901
(Month) (Day) (Year)

8. AGE: Years 39 Months 4 Days 21 If less than one day ___ hr. ___ min.

9. Birthplace St. LOUIS (City, town, or county) O MISSOURI (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name JAMES CARTON
13. Birthplace UNK (City, town, or county) 41 IRELAND (State or foreign country)

MOTHER
14. Maiden name UNK
15. Birthplace UNK (City, town, or county) AUSTRALIA 8 (State or foreign country)

16. (a) Informant August Mueller
(b) Address 3938a N. 11 St.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 17, 1941 (Month) (Day) (Year)
(c) Place: burial or cremation Friedens, St. Louis, Mo

18. (a) Signature of funeral director Suedmeyer & Sons
(b) Address 3934 N. 20 St.

19. (a) 2-14-41 (Date received local registrar) (b) Clarence D. Wessler (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEBRUARY day 13th
year 1941 hour 8 minute 30 P. M.

21. I hereby certify that I attended the deceased from APRIL 9, 1935 to ___, 19__
that I last saw her alive on Feb 13th, 1941
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute obstruction of Bowel	48 hrs
Due to: Chronic Encephalitis	
Due to: Post Influenza	100 pst
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations none
Of autopsy none

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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)
(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? (Specify type of place)
(e) While at work? (f) Means of injury

23. Signature A. P. Erich Schulz (M. D. or other) M.D.
Address St. Charles Mo. Date signed 2/14/41

(Licensed Embalmer's Statement on Reverse Side)

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 Alfred F. Boedeker

Licensed Embalmer No. 2663

P. O. Address 4204 Prairie

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.