

FILED FEB 11 1944
Registration District No. **313**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis

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

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

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

In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Christien G. Mueller

3. (b) If veteran, name war None

3. (c) Social Security No. 351-09-0022

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Sophie Mueller

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Sept. 29 1878
(Month) (Day) (Year)

8. AGE: Years 65 Months 4 Days 0
If less than one day hr. min.

9. Birthplace Nagold Germany
(City, town, or county) (State or foreign country)

10. Usual occupation Pharmacist

11. Industry or business Drug Store

12. Name Gottlieb C. Mueller

13. Birthplace Nagold Germany
(City, town, or county) (State or foreign country)

14. Maiden name Christina Blum

15. Birthplace Hagold Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Sophie Mueller

(b) Address Collinsville, Illinois

17. (a) Removal (b) Date thereof 2-2-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stanton, Illinois

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

(b) Address 4700 Washington Blvd.

19. (a) FEB 1 1944 (b) J. F. Bredech
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Madison

(c) City or town Collinsville
(If outside city or town limits, write "RURAL")

(d) Street No. 316 N. Seminary St.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 29
year 1944 hour 1 minute 55 A.M.

21. I hereby certify that I attended the deceased from JAN. 1 1944, to JAN 29th 1944
and that death occurred on the date and hour stated above.

that I last saw her alive on JAN 28th 1944

Immediate cause of death Pulmonary Embolus

Due to Carbuncle on Back of Neck

Other conditions Diabetes Mellitus

Major findings: Of operations NA

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

C. While at work? _____ (Specify type of place) (d) Means of injury _____

23. Signature Arnold Klein (M. D. or other) M.D.
Address 2622 So. Kingshighway Date signed 1/29/44

Duration 2 days

Duration 1 Month

Duration ?

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

8101

8101

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.....

.....
working under my personal supervision.

Registered Apprentice No.....

Signed.....

Albert G. Hopper

Licensed Embalmer No.....

2971

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.