

FILED SEP 30 1944
818

State File No. _____
8112
Registrar's No. _____

Registration District No. _____

Primary Registration District No. 1003

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

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:
4927 Robert
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 50 years
years, months or days

3. (a) PRINT FULL NAME Marie Elizabeth Mueller

3. (b) If veteran, name war X 3. (c) Social Security No. X

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 22, 1873
(Month) (Day) (Year)

8. AGE: 71 Years 5 Months 27 Days If less than one day _____ hr. _____ min.

9. Birthplace Not known Germany
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER { 12. Name Frank Mueller
13. Birthplace Not known Germany
(City, town, or county) (State or foreign country)
14. Maiden name Sophie Altman
15. Birthplace Not known Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Katherine Mueller

(b) Address 4927 Robert Avenue

17. (a) burial (b) Date thereof 9/22/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park
J L Ziegenhein & Sons

18. (a) Signature of funeral director _____
(b) Address 7027 Gravois Avenue

19. (a) SEP 22 1944 (b) J. F. Bredel
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4927 Robert
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 19
year 1944 hour 6 minute 45 A.M.

21. I hereby certify that I attended the deceased from 8-1-
1944 to 9-19- 1944
that I last saw h e alive on 9-19- 1944
and that death occurred on the date and hour stated above

Immediate cause of death bowel obstruction
and myocardial infarction
Cause unknown
Due to Senility of bowel obstruction
Due to _____

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

Major findings:
Of operations _____
Of autopsy _____

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) _____
While at work? _____ (c) Means of injury _____

23. Signature L. F. Murray (M. D. or other) _____
Address 900-R Russell Date signed 9-21-44

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..... *B. P. Kidwell*

Licensed Embalmer No. *3877*

P. O. Address *7027 Gravois*

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.