

FILED JAN 20 1945  
318

Primary Registration District No. 1003

Registrar's No. 101

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 4 days  
73-4-0 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Bertha Mueller

3. (b) If veteran, name war. no 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced. Widow  
6. (b) Name of husband or wife Charles 6. (c) Age of husband or wife if alive. \_\_\_\_\_ years

7. Birth date of deceased Sept. 2 1871  
(Month) (Day) (Year)

8. AGE: Years 73 Months 4 Days 0 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace St. Louis Mo. 11  
(City, town, or county) (State or foreign country)

10. Usual occupation House Work

11. Industry or business \_\_\_\_\_

12. Name John Busch  
13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)  
14. Maiden name Doretta Dickmann  
15. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Carl J. Mueller  
(b) Address 4032 Hartford

17. (a) Cremation (b) Date thereof Jan. 6 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mo. Crematory

18. (a) Signature of funeral director Mr. Schumacher  
(b) Address 3023 Meramec

19. (a) JAN 5 1945 (b) [Signature]  
(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. 4032 Hartford  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 2  
year 1945 hour 6 minute 45 P. M.

21. I hereby certify that I attended the deceased from 12-15-44  
2, 1944, to 1-2, 1945  
that I last saw h.w. alive on 1-2-45, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Squamous cell carcinoma of cervix.

Due to HS  
Due to \_\_\_\_\_  
Other conditions Presbytic lens.  
(Include pregnancy within 3 months of death) 3 da

Major findings of operations Propag squamous cell ca.  
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?

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) red  
Address 3115 B Grand Date signed 1/2/45

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

MOTHER FATHER

Duration ?  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

3115 do [unclear]  
P105 1600  
Pa. 3952 Study [unclear]  
FL 2/112

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**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, fact should be so stated above.**