

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **667**

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: **3618a Hydraulic**
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **3618a Hydraulic**
(If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3. (a) PRINT FULL NAME **William C. Mueller**

3. (b) If veteran, name war 3. (c) Social Security No. **497-09-7787**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
 6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
 7. Birth date of deceased **Jan. 12 1881**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	64	0	9 hr. min.

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

10. Usual occupation **Warehouse Grand Leader**

11. Industry or business **Warehouse Grand Leader**

12. Name **William Mueller**
 13. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Bertha Karger**
 15. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Ida Dietrich**
 (b) Address **3618 Hydraulic**

17. (a) **Burial** (b) Date thereof **Jan. 24, '45**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Wacker-Belder**
 (b) Address **3634 Gravois Ave.**

19. (a) **JAN 23 1945** **J. F. Bredich**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **21**
 year **1945** hour **8** minute **15 P.** M.

21. I hereby certify that I attended the deceased from **Jan. 13**
 19 **45** to **Jan. 21** 19 **45**;

that I last saw him alive on **Jan. 21** 19 **45**;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Congestion of Lungs** Duration **4 days**

Due to **Chronic Endocarditis** 6 mons
 Due to **Chronic Nephritis** 6 mons

Other conditions **1/21**
(Include pregnancy within 3 months of death)

Major findings: Of operations PHYSICIAN

Of autopsy 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?

While at work (Specify type of place) (e) Means of injury **C**

23. Signature **Dr. Linspan** (M. D. or other) **R.O.**
 Address **3739 Gravois** Date signed **1/22/45**

WRITE PLAINLY - USE UNFADING INK - MAKE A COPY

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.