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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 16 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4627

State File No. _____

Registration District No. **318**

Primary Registration District No. **100**

Registrar's No. **1072**

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis

(c) Name of hospital or institution: Lutheran Hospital
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Mehlville, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. Rt. 8 Box 312 Rural
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Julius A. Mueller

3. (b) If veteran, name war No

3. (c) Social Security No. None

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 December 18 1861
(Month) (Day) (Year)

8. AGE: Years <u>83</u>	Months <u>4</u>	Days <u>131</u>	If less than one day hr. _____ min. _____
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9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name Chas. P. Mueller

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

14. Maiden name Louisa Hill

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

16. (a) Informant Wm. Crecelius

(b) Address Rt. 8 Lemay, Mo.

17. (a) Burial (b) Date thereof Feb. 3, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Pauls Ev. Cem. Olivette, Mo.

18. (a) Signature of funeral director C. Hoffmeister U. & L. Co.
7814 S. Broadway

(b) Address _____

19. (a) FEB 3 1945 (b) J. F. Breckner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 31
year 1945 hour 11 minute 20 a. m.

21. I hereby certify that I attended the deceased from 1/26 1945 to 1/31 1945
that I last saw him alive on 1/31 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to Severe arteriosclerosis

Other conditions CH
(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? _____ (e) Means of injury _____

23. Signature C. R. Hawley (M. D. or other) _____
Address 7219 Michigan Date signed 2/2/45

Dr. Hawker

7/19
Hickman
0293

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

Harry J. Schumacher

Licensed Embalmer No. *2679*

P. O. Address *732 Lemay*

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.