

FILED JUL 13 1945

Primary Registration District No. **1003**

Registrar's No. **5560**

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:
St. Lukes Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 weeks**
(Specify whether
In this community **Life.**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **96**
(c) City or town **Rural - Kirkwood** **8 NR-**
(If outside city or town limits, write "RURAL")
(d) Street No. **528 W. Watson Rd. Kirkwood Mo.**
(If rural, give location)
(e) Citizen of foreign country? **No.** / (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Henry P. Mueller**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Nellie** 6. (c) Age of husband or wife if alive **56** years
7. Birth date of deceased **Dec. 14th, 1870**
(Month) (Day) (Year)

8. AGE: Years **64** Months **6** Days **11** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Foundry**

11. Industry or business _____

FATHER { 12. Name **Frank Mueller**
13. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)
MOTHER { 14. Maiden name **Rose Macklin**
15. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Nellie P. Mueller**
(b) Address **528 W. Watson Rd, Kirkwood**

17. (a) **Cremation** (b) Date thereof **6/27/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Valhalla Crematory**

18. (a) Signature of funeral director **John J. ...**

(b) Address **7027 Gravois Ave.**

19. (a) **J. F. ...** (Registrar's signature)
(Date of registration) **JUN 27 1945**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **24th**,
year **1945**, hour _____ minute **15** P. M.

21. I hereby certify that I attended the deceased from **Jan 2**, 19**45** to **June 24**, 19**45**
that I last saw him alive on **June 24**, 19**45**
and that death occurred on the date and hour stated above.
Immediate cause of death **Pneumonia** Duration _____

Due to **Urinary**

Due to **Carcinoma of Bladder**

Other conditions (Include pregnancy within 3 months of death) **52**

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) **No**
(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 **0**

23. Signature **John J. ...** (M. D. or other) **6**
Address **220 ...** Date signed **7/26**

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

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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address 7027 Travis

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.