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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 1 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

20289

State File No.

Registration District No. 11V

Primary Registration District No. 5428

Registrar's No. 105

1. PLACE OF DEATH:

(a) County FRANKLIN

(b) City or town SULLIVAN? Rural Boone

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1 Imp

(If not in hospital or institution, write street number or location)

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

In this community 13 days.

years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin 36

(c) City or town Sullivan, Rural

(If outside city or town limits, write "RURAL")

(d) Street No. 0

(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME DARLENE MUELLER

3. (b) If veteran, name war CHILD

3. (c) Social Security No. ----

4. Sex Female

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 May 20, 1945 (Month) (Day) (Year)

8. AGE: Years | Months | Days 13 | If less than one day hr. min.

9. Birthplace Sullivan (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Geo. H. Mueller
13. Birthplace Sullivan, (City, town, or county) Missouri. (State or foreign country)

MOTHER
14. Maiden name Amanda Mesger
15. Birthplace Sullivan, (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Geo. H. Mueller.

(b) Address Sullivan, Missouri.

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

(c) Place: burial or cremation Smith Cemetery

18. (a) Signature of funeral director Thos. T. Choffer

(b) Address Sullivan, Missouri.

19. (a) June 15-1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2nd year 1945 hour 12 minute 20 P M.

21. I hereby certify that I attended the deceased from May 20, 1945, to June 12, 1945; that I last saw her alive on May 23, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hydrocephalus	life
Spina bifida	life
Due to birth deformities	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations none

Of autopsy none

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 O A Prastar (M. D. or other)

Address Sullivan Mo Date signed 6/2/45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 7-10-45

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 Edgar W. Laffoon
Licensed Embalmer No. 13394
P. O. Address Sullivan Mo

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, above space should be left blank.