

FILED APR 5 1946
318
Registration District No.

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County..... St. Louis
(b) City or town..... St. Louis
(c) Name of hospital or institution:
4722 Michigan
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... Life
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Anna Mueller

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

4. Sex Female / 5. Color, or race White
6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if

7. Birth date of deceased..... July 10 1868
(Month) (Day) (Year)

8. AGE: Years 77 Months 8 Days 14 If less than one day hr. min.

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

10. Usual occupation At Home

11. Industry or business.....

MOTHER FATHER { 12. Name Not Known
13. Birthplace Not Known (State or foreign country)
14. Maiden name Not Known
15. Birthplace Not Known (City, town, or county) (State or foreign country)

16. (a) Informant Edna Mueller
(b) Address 4722 Michigan

17. (a) Burial (b) Date thereof 3/27/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director J.L. Ziegenhein & Sons

(b) Address 7027 Gravois

19. (a) MAR 27 1946 (b) J.F. Bradack (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County.....
(c) City or town St. Louis
(d) Street No. 4722 Michigan
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24
1946 hour 6 minute 25 P. M.

21. I hereby certify that I attended the deceased from 5-22-46
to 3-24 1946
that I last saw her alive on March 24 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction
Duration 8-10 H.

Due to Chronic Myocarditis 1 year

Due to Senility 1 1/2

Other conditions Fracture Rt femur 8 mo
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Of operations 18
Of autopsy 18
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) Accident
(b) Date of occurrence July 1943
(c) Where did injury occur? Home
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

See above
While at work? (Specify type of place) (e) Means of injury Fall

23. Signature William W. Fogarty (M.D. or other) M.D.
Address 2602 So Grand Date signed 3/20/46

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

11330

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.