No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

11315

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. FILED MAR 24 1947 8

Primary Registration District No. 1003

Registrar's No. 2752

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Pacific Hospital O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 50 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Webster Groves 7
(If outside city or town limits, write "RURAL")

(d) Street No. 421 California N.R. 4
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) 1

If yes, name country _____

3. (a) PRINT FULL NAME William Theodore Mueller

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex male O

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Anna E. Mueller

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased Feb. (Month) 7th (Day) 1869 (Year)

8. AGE: Years 78 | Months 1 | Days 6 | If less than one day ___ hr. ___ min.

9. Birthplace St. Jacob, Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Retired machinist

11. Industry or business _____

FATHER
12. Name Theodore Mueller
13. Birthplace _____ (City, town, or county) Germany 4 (State or foreign country)

MOTHER
14. Maiden name Elizabeth Havdrick
15. Birthplace _____ (City, town, or county) Germany 4 (State or foreign country)

16. (a) Informant Dr. Allen Mueller
(b) Address 132 Ringer Rd.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 3-15-47 (Month) (Day) (Year)
(c) Place: burial or cremation St. Jacob, Ill.

18. (a) Signature of funeral director Wagoner Mortuary
(b) Address 4161 Liddell Blvd.

19. (a) MAR 15 1947 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13
year 1947 hour 12 minute 48 P.M.

21. I hereby certify that I attended the deceased from 3/1, 1947, to 3/13, 1947
that I last saw him alive on 3/13, 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pneumonia Hypostatic	2 day
Due to: Post operative Complication operation Laporotomy	10 day
Due to:	
Other conditions: Hemiplegia c̄ aphasia (Include pregnancy within 3 months of death)	2 yrs

Major findings: Of operations: Fibrous adhesion obstructing lower (ileum) Ileum

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) O

While at work? _____ (e) Means of injury _____

23. Signature Louis F. Stephens (M. D. or other) M.D.

Address Mo. Pac Hospital Date signed 3/13/47

(Licensed Embalmer's Statement on Reverse Side)

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 Elmer Grotke

Licensed Embalmer No. 3351

P. O. Address St Louis 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, fact should be so stated above.