

No. 2
12-45
17-39
X47070

FILED MAY 9 1947 318

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Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis

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

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

(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 _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1649 Macklind Avenue
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

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3. (a) PRINT FULL NAME Laura Mueller

3. (b) If veteran, name war No. 3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27
year 1947 hour 10:05 minute A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

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

6. (b) Name of husband or wife Max Mueller, Dec'd 2/17/46 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased January 9, 1875
(Month) (Day) (Year)

that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Fractured right hip; Arteriosclerosis; suffered when deceased fell on the driveway while raking the yard on the north side of her home, at 1649 Macklind Av., on April 14, 1947; about 12:40 P.M.

Due to ACCIDENT.

Duration

8. AGE: Years 72 Months 3 Days 18 If less than one day hr. min.

Other conditions 1800
(Include pregnancy within 3 months of death)

Major findings: 29
Of operations _____

PHYSICIAN

Of autopsy No autopsy

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 April 14, 1947

(c) Where did injury occur? Residence, St. Louis, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

(Specify type of place) _____
While at work? _____ (Type) Means of injury see above

23. Signature J. F. Brebeck (M.D. or other) _____
Address _____ Date signed 4/27/47

MOTHER FATHER

9. Birthplace Gotha, Germany (City, town, or county) (State or foreign country) 4

10. Usual occupation At home

11. Industry or business Housewife

12. Name Frederick Oemus

13. Birthplace Germany (City, town, or county) (State or foreign country) 4

14. Maiden name ? (City, town, or county) (State or foreign country) 4

15. Birthplace Germany (City, town, or county) (State or foreign country) 4

16. (a) Informant Edgar F. Mueller

(b) Address 8917 Moritz Avenue, Brentwood, Mo.

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1/30/47
(Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director Robert J. Ambruster, Inc.

(b) Address Clayton Rd. at Concordia Lane

19. (a) APR 28 1947 (Date of issue of certificate) (b) J. F. Brebeck (Registrar's signature)

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.....

Arnold W. Schoene

Licensed Embalmer No. *3864*

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.