V. S. No. 2
50M—1/47
Rev. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUN 23 1947

Registration District No. 317

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22989

Primary Registration District No. 607

Registrar's No. 1214

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

1. PLACE OF DEATH:
(a) County: St Louis Co
(b) City or town: St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Miller Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 3 Month (Specify whether years, months or days)
In this community: 3 Month

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: St Louis
(c) City or town: Prospect Hill Mo
(If outside city or town limits, write "RURAL")
(d) Street No.: 596 Scranton Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Matt Mueller
3. (b) If veteran, name war: None
3. (c) Social Security No.: None
4. Sex: Male
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: March (Month) 5 (Day) 1869 (Year)

8. AGE: Years 78 | Months 3 | Days 8 | If less than one day: hr. 1 min.

9. Birthplace: Russia (City, town, or county) (State or foreign country)
10. Usual occupation: Blacksmith
11. Industry or business:

MOTHER
12. Name: Unknown
13. Birthplace: Germany (City, town, or county) (State or foreign country)

FATHER
14. Maiden name: Unknown
15. Birthplace: Germany (City, town, or county) (State or foreign country)

16. (a) Informant: Agnes Klann
(b) Address: 4326 Wyoming
17. (a) Burial: (Burial, cremation, or removal) (b) Date thereof: June 18-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Sunset Burial Park
18. (a) Signature of funeral director: Diedrich F. Hoke
(b) Address: 8319 Halls Ferry Rd
19. (a) 6-17-47 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: June day: 15 year: 1947 hour: 7:45 minute: a. M.

21. I hereby certify that I attended the deceased from Jan. 14th, 1947 to June 15th, 1947 that I last saw him alive on June 14th, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Myocarditis	2 days
Due to: 131	
Due to:	
Other conditions (Include pregnancy, within 3 months of death): Chr. Arteriosclerosis and Nephritis	6 Mo.

Major findings:
Of operations: no
Of autopsy: no

PHYSICIAN — Underline the cause of 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? (Means of injury)

23. Signature: W. H. Walter M.D.
Address: 3608 S. Grand Blvd. Date signed: 6/17/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

JUL 23 1946

AUG 21 1946

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 Henry M. Brammer

Licensed Embalmer No. 4200

P. O. Address St. Louis

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.