

S. No. 2
1-1/47
5-17-39

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36104**
Registrar's No. **9763**

FILED NOV 3 1947

318

Registration District No.

1003

Primary Registration District No.

1. PLACE OF DEATH:

(a) County.....
(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 **5 Wks**
(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. **3644 Bamburger**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Theresa Mueller**

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

4. Sex **F** / 5. Color or race **W** 6. (a) Single, widowed, married, divorced **W 2**

6. (b) Name of husband or wife **Gottfried** 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **Feb. 23, 1861**
(Month) (Day) (Year)

8. AGE: Years **86** Months **7** Days **27** If less than one day hr. min.

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

10. Usual occupation **Home**

11. Industry or business.....

12. Name **Wilhelm Wiegand** **Germany 4**

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

14. Maiden name **Theresa K. Rchner**

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

16. (a) Informant **Maria Buegler**
(b) Address **3644 Bamburger**

17. (a) **Burial** (b) Date thereof **Oct. 23, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sunset Burial Pk.**

18. (a) Signature of funeral director **Waska-Heldub & Co.**
(b) Address **3634 Gravois, St. Louis, Mo.**

19. (a) **OCT 21 1947** (b) **J. F. Bredeek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **20**
year **1947** hour **9:** minute **20** P. M.

21. I hereby certify that I attended the deceased from.....
..... 19....., to..... 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death **Stroke Left Ventr.**
Chronic Calcification of the Aorta
When she fell at Child Hosp.
While playing on a street
Oct. 3, 1947
Duration
1947

Other conditions.....
(Include pregnancy within 8 months of death)

Major findings:
Of operations.....

Of autopsy.....

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **Car accident**

(b) Date of occurrence **Oct 3 1947**

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

(d) Did injury occur in or about home, on farm, or industrial place, in public place? **City Hospital**
(Specify type of place)

While at work?..... (e) Means of injury **Car**

23. Signature **Laborat J. Taylor** (M. D. or other) **3**
Address **Deputy Coroner** Date signed **10.21.47**

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

MOTHER FATHER

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.....

Frank J. O'Connell

Licensed Embalmer No.....

2675

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.