

FILED MAR 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4470**

BIRTH NO. ~~115~~ REG. DIST. NO. **115** PRIMARY REG. DIST. NO. **5433** Registrar's No. _____

36
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Franklin	
b. CITY (If outside corporate limits, write RURAL and give township) Rural Union Life Line	c. LENGTH OF STAY (in the place)	c. CITY (If outside corporate limits, write RURAL and give township) Rural, Union	36
d. FULL NAME OF HOSPITAL OR INSTITUTION	(If not in hospital of institution, give street address or location)	d. STREET ADDRESS (If rural, give location) Union Mo R 1	0

3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) Ida c. (Last) Mueller	4. DATE OF DEATH (Month) (Day) (Year) Mar 2 1949			
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Feb 27 1881	9. AGE (In years last birthday) 68 IF UNDER 1 YEAR Months 3 IF UNDER 12 HOURS Hours 3 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Union Mo R 10	12. CITIZEN OF WHAT COUNTRY USA	

13a. FATHER'S NAME Benjamin Mueller	13b. MOTHER'S MAIDEN NAME Catherine Voss	14. NAME OF HUSBAND OR WIFE Joseph A Mueller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Joseph A Mueller
		ADDRESS Union Mo R 1

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Chronic Myocarditis		2 yrs
ANTECEDENT CAUSES	DUE TO (b)		
<i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS	Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION No operation	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Feb 19 49** to **Mar 1 1949**, that I last saw the deceased alive on **Feb 26 1949**, and that death occurred at **8:30 AM** from the causes and on the date stated above.

23a. SIGNATURE J. H. Matthews M.D.	(Degree or title)	23b. ADDRESS Beaufort Mo	23c. DATE SIGNED 3-2-49
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 3-5-49	24c. NAME OF CEMETERY OR CREMATORY St. Josephs Cath Cem	24d. LOCATION (City, town, or county) (State) Union Mo R 1
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DATE REC'D BY LOCAL REG. Mch. 3-1949	REGISTRAR'S SIGNATURE J. T. Cooper, Edna J. Cooper	25. FUNERAL DIRECTOR'S SIGNATURE E. H. Jensen	ADDRESS Beaufort Mo
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RECEIVED
District Health Officer No. 9,
Date Filed 3-7-49

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 _____

E. H. Jenne

Student Embalmer No. _____

working under my personal supervision.

Signed _____

E. H. Jenne

Signed _____
Student Embalmer

Licensed Embalmer No. 3076

P. O. Address Beaufort 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.