

FILED MAR 4 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5851

State File No.

9200

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

BIRTH NO. _____ REG. DIST. NO. 306 PRIMARY REG. DIST. NO. 6048 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY <u>ST. CHARLES</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>ST. CHARLES</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>O'FALLON</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>O'FALLON</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____		d. STREET ADDRESS (If rural, give location) _____	
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARGARET</u> b. (Middle) _____ c. (Last) <u>MULLER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 17 1949</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____	8. DATE OF BIRTH <u>OCTOBER-16-1868</u>
9. AGE (In years last birthday) <u>80</u>		10. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>TIPTON MO</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>PETER MULLER</u>		13b. MOTHER'S MAIDEN NAME <u>EMERICK</u>	
14. NAME OF HUSBAND OR WIFE _____		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>JULIA R. MULLER O'FALLON MO</u> ADDRESS _____	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>pulmonary edema</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>rupture of gall bladder</u> DUE TO (c) <u>stone in cystic duct</u> 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>generalized arteriosclerosis</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>586X</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____		22. I hereby certify that I attended the deceased from <u>Jan 1948</u> , to <u>Feb 1949</u> , that I last saw the deceased alive on <u>16 Feb, 1949</u> and that death occurred at <u>1:02 a. m.</u> , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <u>Laurence B. Behm MD</u>		23b. ADDRESS <u>O'Fallon Mo</u>	
23c. DATE SIGNED <u>2-25-49</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
24b. DATE <u>FEB. 19-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ASSUMPTION</u>	
24d. LOCATION (City, town, or county) (State) <u>O'FALLON MO</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. Keithley</u> ADDRESS <u>O'FALLON MO</u>	
DATE REC'D BY LOCAL REG. <u>Feb 25-49</u>		REGISTRAR'S SIGNATURE <u>E. Keithley</u> ADDRESS <u>280 O'FALLON MO</u>	

(Licensed Embalmer's Statement on Reverse Side)

Date Filed _____
District File Number 3-3-49
District Health Officer No. 9,
RECEIVED

MAY 24 1957

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed *E. A. Smith*

Licensed Embalmer No. 877

P. O. Address Ballou 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.