

FILED JUN 3 1949

STANDARD CERTIFICATE OF DEATH

4532 State File No. 18436
6-2-36 Registrar's No. 10

BIRTH NO.		REG. DIST. NO. 363		PRIMARY REG. DIST. NO. 6736		Registrar's No. 10	
1. PLACE OF DEATH a. COUNTY Warren				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marthasville		c. LENGTH OF STAY (In this place) 2 years		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) Unknown	
d. FULL NAME OF HOSPITAL OR INSTITUTION Emmaus Home				3. NAME OF DECEASED a. (First) Theodore b. (Middle) H. c. (Last) Mueller			
4. DATE OF DEATH (Month) (Day) (Year) May 14 1949		5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	
8. DATE OF BIRTH June 4, 1898		9. AGE (In years last birthday) 50		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME John G. Mueller		13b. MOTHER'S MAIDEN NAME Mary Schultenberg	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME John S. Reich	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Epilepsy ANTECEDENT CAUSES Nephritis Asbroid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Freeble muddled				INTERVAL BETWEEN ONSET AND DEATH Year 1 yr life	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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) 3533		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	
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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.	
23a. SIGNATURE J. C. Johnson M.D.		23b. ADDRESS Marthasville Mo		23c. DATE SIGNED May 15/49		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE May 17, 1949		24c. NAME OF CEMETERY OR CREMATORY New Bethlehem		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri		25. GENERAL DIRECTOR'S SIGNATURE John S. Reich	
DATE REC'D BY LOCAL REG. May 15/49		REGISTRAR'S SIGNATURE J. C. Johnson		334		ADDRESS Marthasville, Mo.	

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JUN 2 1949

JUN 1 3 1949

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 _____

working under my personal supervision. _____ Student Embalmer No. _____

Student
Student Embalmer

Signed Samuel V. Lichtenberg

Licensed Embalmer No. 4318

P. O. Address Mathiasville, 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.