S. No. 300
. 10-48

FILED AUG 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28369

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6854

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis Hospital
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Johns Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
d. STREET ADDRESS (If rural, give location) 828 Wall St.,

3. NAME OF DECEASED (Type or Print)
a. (First) Kenneth
b. (Middle) Muehlbauer
c. (Last)

4. DATE OF DEATH (Month) (Day) (Year) Aug 5th 1949

5. SEX Male
6. COLOR OR RACE whitw
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single
8. DATE OF BIRTH June 14th, 1948
9. AGE (In years last birthday) 1 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Otto Muehlbauer
13b. MOTHER'S MAIDEN NAME Elizabeth Livingston
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Otto Muehlbrauer — ADDRESS 828 Wall St.,

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Meningo-Encephalitis Etiology unk — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Cranio stenosis Mental retardation — Since birth

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
20. AUTOPSY? YES [X] NO [ ]

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) 84a
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR? 2233

22. *I hereby certify that I attended the deceased from* 12-1-, 1948, *to* 8-5, 1949, *that I last saw the deceased alive on* 8-5-, 1949 *and that death occurred at* 12:40 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Leha Stephenson
23b. ADDRESS 3x84 Ivanhoe
23c. DATE SIGNED Aug 5-49

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 8/8/49
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. AUG 7 1949
REGISTRAR'S SIGNATURE J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE Diedrich F. Home — ADDRESS 8319 Hallsferry

(Licensed Embalmer's Statement on Reverse Side)

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

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. .....

Signed J. Wm Binkley

Signed.....
Student Embalmer

Licensed Embalmer No. 3657

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.