

FILED DEC 9 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38439**

| | | | | | | | |
|--|--|---|---|--|---|---|---|
| BIRTH NO. <u>124</u> | | REG. DIST. NO. <u>316</u> | | PRIMARY REG. DIST. NO. <u>6075</u> | | Registrar's No. <u>423</u> | |
| 1. PLACE OF DEATH a. COUNTY <u>St. Francois</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Francois, Mo.</u> c. LENGTH OF STAY (in this place) d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Francois</u> d. STREET ADDRESS (If rural, give location) <u>810 Monroe</u> | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>ALONZO</u> b. (Middle) <u>L.</u> c. (Last) <u>MUELLER</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 29, 1949</u> | | | | |
| 5. SEX <u>Male</u> | | 16. COLOR OR RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | | 8. DATE OF BIRTH <u>April 2, 1878</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Centerville, Mo. 1</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Witchel Mueller</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Caroline Degenore</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Dora Mueller</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>Dora Mueller, St. Francois 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, asthenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypostatic Pneumonia</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Cerebral softening</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> |
| 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) | | | |
| 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? | | | |
| 22. I hereby certify that I attended the deceased from <u>June 20, 1947</u> , to <u>Nov. 29, 1949</u> , that I last saw the deceased alive on <u>Nov. 29, 1949</u> , and that death occurred at <u>4:10 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Type or Print) <u>Theodore Paul D.O.</u> | | | | 23b. ADDRESS <u>Flat River Mo.</u> | | 23c. DATE SIGNED <u>11/30/49</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>Dec 1/1949</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery, Steadington, Mo.</u> | | 24d. LOCATION (City, town, or county) (State) | |
| DATE REC'D BY LOCAL REG. <u>Dec. 2, 1949</u> | | REGISTRAR'S SIGNATURE <u>Ether Rudolph</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond Caldwell</u> ADDRESS <u>Flat River Mo.</u> | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 12-6-49
District Health Officer No. 4
District File Number 1249-1592
Date Filed _____

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 R. Caldwell

Licensed Embalmer No. 2531

P. O. Address Flat River, 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.