S. No. 300
Rev. 10-48

FILED APR 9 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10463

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2851

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) StLouis
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) StJohns Hospi tal

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Illinois
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nashville 8128
d. STREET ADDRESS (If rural, give location) 103 So Mill St

3. NAME OF DECEASED (Type or Print) a. (First) Henry b. (Middle) John c. (Last) Mueller

4. DATE OF DEATH (Month) (Day) (Year) 3-22-1951

5. SEX Male 0
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 1
8. DATE OF BIRTH 7023-1874
9. AGE (In years last birthday) 76 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) Barber
10b. KIND OF BUSINESS OR INDUSTRY ----
11. BIRTHPLACE (State or foreign country) 1 Knasas
12. CITIZEN OF WHAT COUNTRY? US

13a. FATHER'S NAME John Mueller
13b. MOTHER'S MAIDEN NAME Caroline Koch
14. NAME OF HUSBAND OR WIFE Ruth

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. no
17. INFORMANT'S SIGNATURE OR NAME Ruth Mueller ADDRESS Nashville. Ill

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) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Miliary Tuberculosis — 5 Days

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Arteriosclerosis — 0 1A 1H

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION Ca of Prostate
20. AUTOPSY? YES ☐ 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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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* 5-10 a *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) [illegible]
23b. ADDRESS 609 [illegible]
23c. DATE SIGNED Mar 26 51

24a. BURIAL, CREMATION, REMOVAL (Specify) removal 3
24b. DATE 3-26-51
24c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery
24d. LOCATION (City, town, or county) (State) Nashville, Illinois

DATE REC'D BY LOCAL REG. MAR 27 1951
REGISTRAR'S SIGNATURE J B Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Svc 4104 Manchester

(Licensed Embalmer's Statement on Reverse Side)

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 Ronald O Yahnke

Signed.....
Student Embalmer

Licensed Embalmer No 3917

P. O. Address [illegible] 10 M

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.