

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **40542**
 Registrar's No. **10162**

DEC 2 1952

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY Clinton	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN New Baden 8120	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) Amalie b. (Middle) Catherine c. (Last) Mueller			4. DATE OF DEATH (Month) (Day) (Year) Nov. 4, 1952
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH July 3, 1884
9. AGE (In years, last birthday) 68		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) New Baden, Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.			
13a. FATHER'S NAME Unknown Mullerich		13b. MOTHER'S MAIDEN NAME Eliza Richter	
14. NAME OF HUSBAND OR WIFE Eugene			
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 Theodora Mowe, 204 So. McGregor ADDRESS Spring Hill, Ala.			
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 CERTIFICATIONS I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis with rupture of coronary artery INTERVAL BETWEEN ONSET AND DEATH 3 hrs ANCECEDENT CAUSES Hemopericardium DUE TO (b) Hemopericardium DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 3 hrs 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 <input checked="" type="checkbox"/> NO <input 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? 4201			
22. I hereby certify that I attended the deceased from Nov. 20, 1951, to Nov. 4, 1952 , that I last saw the deceased alive on Nov. 4, 1952 , and that death occurred at 8:50 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Clarence E. Mueller, M.D.		23b. ADDRESS 631 N. Grand Blvd.	
23c. DATE SIGNED 11-4-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11-4-52	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) New Baden, Ill.	
DATE RECD BY LOCAL REG. NOV 5 1952		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe, 4700 Washington Blvd. ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

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

MAR 12 1958

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 Me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed W. W. Wilkinon

Licensed Embalmer No. 3575

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.