

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32052

State File No.

7868

FILED SEP 16 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>Incarnate Word Hosp.</b>		e. STREET ADDRESS (If rural, give location) <b>3115 Eads Ave.</b>	<b>2179</b>

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Carl</b>	b. (Middle) <b>P.</b>	c. (Last) <b>Mueller</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>8/23/54</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>2/22/1896</b>	9. AGE (In years last birthday) <b>58 yrs.</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teller</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>1st Nat'l Bank</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Fred Mueller</b>	13b. MOTHER'S MAIDEN NAME <b>Anna Norden</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>Estelle Brudner</b>	ADDRESS <b>3115 Eads Ave.</b>
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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 CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>		<b>3 hrs.</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Myocardial Decompensat</b> DUE TO (c) <b>Bilateral Hydro-Chrom</b>		<b>2 yrs.</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>Bilateral Hydro-Chrom</b>	<b>2 hrs.</b>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>4201</b>
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22. I hereby certify that I attended the deceased from **April 10, 1954**, to **Aug 23, 1954**, that I last saw the deceased alive on **8-23-**, 1954, and that death occurred at **10:45P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Deceased or title) <b>Herman J. Mueller M.D.</b>	23b. ADDRESS <b>9621 Buhlman Rd.</b>	23c. DATE SIGNED <b>8-25-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>8/27/54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
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DATE REC'D BY LOCAL REG. <b>AUG 25 1954</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>E.J. Schnur</b>	ADDRESS <b>3125 Lafayette Ave.</b>
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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 ....., Student Embalmer No..... working under my personal supervision. .

Student.....  
Signature of Student Embalmer

Signed.....  
*Joseph B. Volkman*

Licensed Embalmer No. *41014*  
P. O. Address *3125 Lafayette*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.