

FILED JAN 25 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **2810**BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **137**

1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis,		
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis, Mo.		c. LENGTH OF STAY (in this place) _____	c. CITY OR TOWN 4356 University/City		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 Enroute City Hospital			e. STREET ADDRESS (If rural, give location) 1235 North & South Road		
3. NAME OF DECEASED (Type or Print) William Mueller		a. (First)	b. (Middle) Kleissle	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Jan. 3, 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 13, 1900	9. AGE (In years last birthday) 55	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) Gardner		10b. KIND OF BUSINESS OR INDUSTRY Landscape	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Emil Kleissle		13b. MOTHER'S MAIDEN NAME Josie Parker		14. NAME OF HUSBAND OR WIFE Hazel Kleissle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. W. W. # 1 498-03-9999	17. INFORMANT'S SIGNATURE OR NAME Hazel Layon Kleissle, N.&S. Roads		
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis			INTERVAL BETWEEN DEATH AND DEATH (?)
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardio-vascular - Renal disease			6 mo (?)
		DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4201			
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION 442x			20. AUTOPSY? YES <input 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? _____			
22. I hereby certify that I attended the deceased from 9-12 ¹⁹⁵⁵ to 1-3 , 1956, that I last saw the deceased alive on 11-12 , 1955, and that death occurred at 7:45 A. m. , from the causes and on the date stated above.					
23a. SIGNATURE Martyn Richardson		(Degree or title)	23b. ADDRESS 2335 Brown Rd.		23c. DATE SIGNED 1-6-56
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-6-56	24c. NAME OF CEMETERY OR CREMATORY National Cemetery	24d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.		
DATE REC'D BY LOCAL REG 1-5-1956	REGISTRAR'S SIGNATURE Carl Smith MO		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington,		

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

A 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 *John S. Plenne*.....

Licensed Embalmer No. *419*.....

P. O. Address *St. Louis*.....

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.