

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32283

FILED SEP 26 1956

State File No.

8315

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 MISSOURI b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place) 70 yrs		c. CITY OR TOWN St. Louis		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 Missouri Baptist Hospital				e. STREET ADDRESS (If rural, give location) 3309 Winnebago Street			
3. NAME OF DECEASED (Type or Print) a. (First) LOUISA		b. (Middle) A.		c. (Last) MUELLER		4. DATE OF DEATH (Month) (Day) (Year) Sept. 7, 1956	
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED/ WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Aug. 17, 1886	
9. AGE (In years last birthday) 70		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) housewife			10b. KIND OF BUSINESS OR INDUSTRY at home			11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Peter Seibert		13b. MOTHER'S MAIDEN NAME Katherine Kaltenschneb		14. NAME OF HUSBAND OR WIFE Henry L. Mueller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Henry L. Mueller, 3309 Winnebago St.			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerotic heart disease C. Failure DUE TO (c) hypertension Diabetes Mellitus II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 420.0				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 8-18-56 , 19 56 , to 9-7 , 19 56 , that I last saw the deceased alive on 9-56 , 19 56 , and that death occurred at 6:00 Am. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) J. E. Carney M.D.				23b. ADDRESS 906 Olive St		23c. DATE SIGNED 9-8-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE Sept. 10, 1956		24c. NAME OF CEMETERY OR CREMATORY St. Peter Cemetery		24d. LOCATION (City, town, or county) (State) Okawville, Illinois	
DATE REC'D BY LOCAL REG. SEP 8 1956		REGISTRAR'S SIGNATURE J. Carl Smith <i>acm</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave.			

(Licensed Embalmer's Statement on Reverse Side)

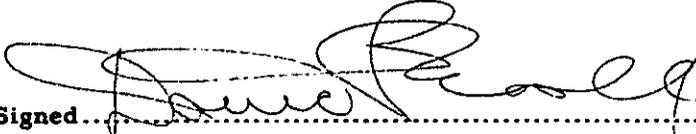
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Joseph E. Carney,
Frisco Building
8 am to 2 pm daily
8 am to 10 am Sat.

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 _____


Licensed Embalmer No. 455

P. O. Address _____


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.