

FILED MAY 13 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13773

STATE FILE NUMBER

Registration District No. 172 Primary Registration District No. 3034 Registrar's No. 33

1. PLACE OF DEATH a. COUNTY <i>Lafayette</i>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Lafayette</i>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Higginsville</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Higginsville</i>		0541 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>202 W. 15th</i>			Length of stay in 1b <i>3 yrs.</i>		d. STREET ADDRESS <i>202 W. 15th</i>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Chas. Mueller</i>				First <i>Chas.</i> Middle <i>Mueller</i> Last <i>Mueller</i>		4. DATE OF DEATH Month <i>April</i> Day <i>14</i> Year <i>1957</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 9, 1871</i>		9. AGE (In years last birthday) <i>86</i>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Farm Owner</i>		11. BIRTHPLACE (City and state or country) <i>Higginsville, Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Adam Mueller</i>				14. MOTHER'S MAIDEN NAME <i>Charlotte Stueber</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>496-16-513</i>		17. INFORMANT Address <i>Walter Mueller - Higginsville, Mo.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Arteriosclerotic Hypertension</i> DUE TO (c) <i>Arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i> <i>4 years -</i> <i>4 years -</i>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____									
20d. INJURY OCCURRED - WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		CITY _____ STATE _____			
21. I attended the deceased from <i>March 1950</i> , <i>April 14, 1957</i> last saw ^{her} him alive on <i>April 14-57</i> Death occurred at <i>6:45</i> <i>P.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>W. Kappenburg, M.D.</i>				22b. ADDRESS <i>Higginsville, Mo.</i>		22c. DATE SIGNED <i>Apr 15-57</i>			
23a. BURIAL, CREMATION, REBURYAL (Specify)		23b. DATE <i>Apr. 17, 1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Bread</i>		23d. LOCATION (City, town, or county) (State) <i>2 mi. S. - Higginsville, Mo.</i>				
24. FUNERAL DIRECTOR <i>Hegars-Pickel - Higginsville, Mo.</i>			ADDRESS <i>Higginsville, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>May 8 - 1957</i>		25. REGISTRAR'S SIGNATURE <i>Marie D. Bailey</i>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

5430

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 *Forest H. Reekhal*
.....

Licensed Embalmer No. *428*

P. O. Address *Highway 116*

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.