

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15068

STATE FILE NUMBER 3559

FILED APR 26 1957

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 3559

Health & Welfare  
Public Service

300  
1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, give TOWNSHIP only) OR TOWN <b>St. Louis</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>		Length of stay in lb <b>52 yrs</b>		d. STREET ADDRESS (If outside, give location) <b>3216 Winnebago St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALMA</b> Middle <b>MUELLER</b> Last <b>MUELLER</b>				4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>1957</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 16, 1905</b>		9. AGE (In years last birthday) <b>52</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>anesthetist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>registered nurse</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Fred William Mueller</b>				14. MOTHER'S MAIDEN NAME <b>Minna Bode</b>			
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. <b>487-36-6808</b>		17. INFORMANT Address <b>R. Otellia Eggers, Washington, Mo.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of breast with widespread metastases</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Widespread metastases</b> DUE TO (c) <b>metastases</b>							INTERVAL BETWEEN ONSET AND DEATH <b>16 mos. 16 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>170x</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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 <b>11-57</b> Month <b>4</b> Day <b>12</b> Year <b>57</b> a. m. <b>57</b> 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 <b>St. Louis</b>		COUNTY <b>St. Louis</b> STATE <b>Missouri</b>	
21. I attended the deceased from <b>Jan 1, 1957</b> to <b>4/12/57</b> and last saw her/him alive on <b>4/11/57</b> Death occurred at <b>12:25 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Donald T. Johnson, M.D.</b> (Degree or title) <b>M.D.</b>				22b. ADDRESS <b>3606 Gravois</b>		22c. DATE SIGNED <b>4/12/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>Apr. 15, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>		
24. FUNERAL DIRECTOR <b>BEIDERWIEDEN FUN. H. INC., 1936 St. Louis</b>			ADDRESS		25. DATE RECD. BY LOCAL REG. <b>APR 15 '57</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MO</b>	

Dr. Donald Behrens  
3606 Gravois Ave  
2-3 PM

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 Delis J. Krupin

Licensed Embalmer No. 349

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.