

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034529

STATE FILE NUMBER

9051

1003

FILED OCT 10 1958

Registration District No. 318 Primary Registration District No.

Registrar's No.

5. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Masonic Home of Missouri</b>				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, Missouri</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>Masonic Home of Mo</b>			Length of stay in lb <b>8-27-58</b>		d. STREET ADDRESS (If outside, give location) <b>5351 Delmar</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Mueller</b> Last <b>Mueller</b>				4. DATE OF DEATH Month <b>9</b> Day <b>18</b> Year <b>58</b>				
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-1-1862</b>		9. AGE (In years last birthday) <b>95</b>	IF UNDER 1 YEAR Months <b>25</b> Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Phillip Steller</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Kiestner</b>			14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Masonic Home of Mo. 5351 Delmar Blvd.</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>CEREBRAL HEMORRHAGE</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>HYPERTENSION</b> <b>331X</b>						<b>2 1/2 YRS</b>		
DUE TO (c) <b>ARTERIOSCLEROSIS, GENERALIZED</b>						<b>2 1/2 YRS</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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 <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		COUNTY STATE		
21. I attended the deceased from <b>1-56</b> , to <b>9-18-58</b> and last saw her alive on <b>9-17-58</b> Death occurred at <b>11:10</b> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Robert A. Hall, M.D.</b>				22b. ADDRESS <b>5351 Delmar</b>		22c. DATE SIGNED <b>9-19-58</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<b>Cremation</b>		<b>9-19-58</b>	<b>Oak Grove</b>		<b>St. Louis, Mo</b>			
24. FUNERAL DIRECTOR ADDRESS <b>A. Kroll 2707 W. Grand</b>				25. DATE RECD. BY LOCAL REG. <b>SEP 19 58</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith Mo</b> <b>mfb</b>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Herbert J. Gar Jr.* .....

Licensed Embalmer No. *4800* .....

P. O. Address *Richwood 27* .....

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.