

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-026992**

**FILED VS AUG 11 1959**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 7100** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis Mo.</b>		Length of stay in 1b		c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis City Hosp. # 1</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2919 GASCONADE</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>IDA C MUEHLHEAUSLER</b>				4. DATE OF DEATH Month <b>July</b> Day <b>30.</b> Year <b>1959</b>					
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT 29 1890</b>	9. AGE (last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WIDOW</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (City and state or country) <b>MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U-S-A</b>		
13a. FATHER'S NAME <b>AUGUST CHRISTMAN</b>			13b. MOTHER'S MAIDEN NAME <b>EMMA META</b>			14. NAME OF HUSBAND OR WIFE <b>EDWARD MUEHLHEAUSLER</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>NONE</b>		17. INFORMANT Address <b>2919 GASCONADE</b> <b>OLIVER SCHELBRINK</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>Myocardial Infarction</b> DUE TO (b) <b>Arteriosclerotic Coronary Thrombosis</b> DUE TO (c) <b>420.1</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes Mellitus</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				
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 _____ a.m. _____ p.m. Month, Day, Year _____			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			COUNTY		STATE	
21. I attended the deceased from <b>7/29/59 9:15 a.m.</b> to <b>7/30/59</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>7/30/59</b> Death occurred at <b>2:15 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree title) <b>John W. Strizick M.D.</b>				22b. ADDRESS <b>1515 Lafayette Ave.</b>		22c. DATE SIGNED <b>7/30/59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL AUG 3 1959</b>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <b>ST. PAUL CHURCHYARD</b>		23d. LOCATION (City, town, or county) <b>ST. LOUIS MO</b>		(State)			
24. FUNERAL DIRECTOR <b>Thomas Kutis 2906 Gravois</b>			25. DATE RECD. BY LOCAL REG. <b>JUL 3 1959</b>		26. REGISTRAR'S SIGNATURE <b>Loard Smith, M.D.</b>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*msb*

**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 *Thomas E. Hill*

Licensed Embalmer No. 4347

P. O. Address 2016 St.

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.