

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030660

FILED VS AUG 27 1959

2 7550

STATE FILE NUMBER

INDEXED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis,</b>		Length of stay in 1b		c. CITY OR TOWN <b>Mo. St. Louis,</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Lukes Hosp.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5321 Winona Ave.</b>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					

3. NAME OF DECEASED (Type or print) First <b>FRIEDA</b> Middle <b>D.</b> Last <b>MUELLER</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>13th</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>12-25-1889</b>	9. AGE (last birthday) <b>69</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>Housework</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state of country) <b>Germany, (Nat)</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
---	--	---	--

13a. FATHER'S NAME <b>Ludwig Miloschütz</b>	13b. MOTHER'S MAIDEN NAME <b>Frödericka Feigl</b>	14. NAME OF HUSBAND OR WIFE <b>Late Engelbert A.</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. _____	17. INFORMANT <b>Albert A. Mueller-5321 Winona Ave.</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>Hypertrophoma of left kidney</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)	DUE TO (b) _____	
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>180X</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 **July 1, 1959** to **Aug 13, 1959** and last saw her alive on **Aug 12, 1959**  
Death occurred at **4:00 A.** m on the date stated above, and to the best of my knowledge from the causes stated.

22a. SIGNATURE (Degree or title) <b>Grant T. Rouse M.D.</b>	22b. ADDRESS <b>100 N. Euclid Ave -</b>	22c. DATE SIGNED <b>8/14/59</b>
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1959 Aug. 17th</b>	23c. NAME OF CEMETERY OR CREMATORY <b>S/S Peter &amp; Paul</b>	23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>
--	------------------------------------	---	--

24. FUNERAL DIRECTOR <b>Kriegshauser-4228 S. Kingshighway</b>	25. DATE RECD. BY LOCAL REG. <b>AUG 14 '59</b>	26. REGISTRAR'S SIGNATURE <b>Roal Smith, M.D.</b>
--	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

9. 211.

6201 9 T SEP

**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 William B White

Licensed Embalmer No. 4381

P. O. Address 123 1st 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.