DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS SEP 22 1959

59-034127
STATE FILE NUMBER

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 8105

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Incarnate Word Hospital
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY: St. Louis
c. CITY OR TOWN: Affton
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 8526 Mathilda Ave.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First ELMER Middle H. Last MUEHLENBROCK
4. DATE OF DEATH: Month Sep. Day 1 Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 3-6-1899
9. AGE (last birthday): 60
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): Sec'y.-O'Fallon Brake
10b. KIND OF BUSINESS OR INDUSTRY: Shoe Co.
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Fred Muehlenbrock
13b. MOTHER'S MAIDEN NAME: Minnie Sears
14. NAME OF HUSBAND OR WIFE: Maude Muehlenbrock
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes World War I
16. SOCIAL SECURITY NO.: 489-05-0329
17. INFORMANT: Maude Muehlenbrock Address: 8526 Mathilda

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Transitional cell carcinoma of urinary bladder — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): _____
DUE TO (c): 181.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1-11-57, to 8-31-59 and last saw her/him alive on 8-31-59
Death occurred at 3:00 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J. M. Macnab M.D.
22b. ADDRESS: 4405 W. Pine.
22c. DATE SIGNED: 9-1-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Sep. 3, 1959
23c. NAME OF CEMETERY OR CREMATORY: Sunset Burial Park
23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.
24. FUNERAL DIRECTOR: Kriegshauser ADDRESS: 4228 S. Kingshighway
25. DATE RECD. BY LOCAL REG.: SEP 1 1959
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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 _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4533

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl 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.