

**FEDERAL BUREAU OF INVESTIGATION - UNITED STATES DEPARTMENT OF JUSTICE**

**U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-037900**

**FILED VS OCT 28 1959**

**2 9581**

STATE FILE NUMBER

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>Mo.</b> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Length of stay in lb <b>5-24-52 to 10-18-59</b>		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 Hoap.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>5351 Delmar Ave</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <del>Janie/Doris/Jan</del> Middle Last <b>JESSIE DODSWORTH MUELLER</b>				4. DATE OF DEATH Month Day Year <b>OCT. 18 59</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>AUG. 25/85</b>		9. AGE (last birthday) <b>74</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <b>8 15 pm</b>	
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 <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		
13a. FATHER'S NAME <b>James A. Mallette</b>			13b. MOTHER'S MAIDEN NAME <b>Emma Mitchell</b>			14. NAME OF HUSBAND OR WIFE <b>Frederick Mueller</b>			
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 <b>Masonic Home of Mo. - 5351 Delmar Blvd.</b> Address					
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>Cereberal Hemmorage</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10-16-59</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <b>331x</b>									
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. <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>1956</b> to <b>1959</b> and last saw her <b>live</b> on <b>10-18-59</b> Death occurred at <b>8:15</b> p.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>3902 Lafayette</b>			22c. DATE SIGNED <b>10/18/59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 21, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis, Missouri</b>			(State)	
24. FUNERAL DIRECTOR <b>Ambruster Mortuary, 6633 Clayton rd.</b>			25. DATE REC'D. BY LOCAL REG. <b>OCT 19 1959</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>				

RECEIVED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*mjk*

**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 *Edward J. Larson*

Licensed Embalmer No. 4788

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.