

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

**=60-017170**

**FILED VS. APR 18 1960**

**2 3803**

STATE FILE NUMBER

ENDED

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</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. John's Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1121 S. Kingshighway</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALMA</b> Middle <b>J.</b> Last <b>MUELLER</b>				4. DATE OF DEATH Month <b>Apr.</b> Day <b>2</b> Year <b>1960</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5-15-1896</b>	9. AGE (last birthday) <b>63</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>Cost Accountant - Glidden Paint Co.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>St. Louis, Mo.</b>		11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>			12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME <b>Cornelius G. Mueller</b>			13b. MOTHER'S MAIDEN NAME <b>Frances Meyrer</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>No</b>			16. SOCIAL SECURITY NO. <b>488-03-9860</b>		17. INFORMANT <b>Cornelia A. Mueller 1121 S. Kingshighway</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>Sudden cardiac arrest, involving</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>shut to abdomen, from</b> DUE TO (c) <b>Cancer of left breast</b>							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>170x</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 checked="" type="checkbox"/> NO <input 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.) <b>170x</b>				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.								
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>2-8-60</b> to <b>4-2-60</b> and last saw her/him alive on <b>3-31-60</b> Death occurred at <b>4:35 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Sam T. Safary M.D.</b>				22b. ADDRESS <b>634 N. Grand Blvd</b>		22c. DATE SIGNED <b>4-4-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Apr. 6, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Churchyard</b>		23d. LOCATION (City, town, or county) <b>St. Louis Co. Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway Blvd.</b>			25. DATE RECD. BY LOCAL REG. <b>APR 5 1960</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed R. W. Stovsund

Licensed Embalmer No. 4007

P. O. Address St. Louis

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