

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 10 years <b>10 years</b>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Little Sisters of the Poor</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2743 Eads Ave.</b>

3. NAME OF DECEASED (Type or print) First <b>Agnes</b> Middle Last <b>Mucke</b>			4. DATE OF DEATH Month <b>November</b> Day <b>9</b> , Year <b>1960</b>	
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5. SEX <b>F</b>	6. COLOR OR RACE <b>W</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>3/31/71</b>	9. AGE (last birthday) <b>89</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>8</b>	IF UNDER 24 HR Hours <b>8</b> Min.
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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>retired</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Lawrence DeLea</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret Collins</b>	14. NAME OF HUSBAND OR WIFE <b>Alexander Mucke</b>
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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>497-20-1075</b>	17. INFORMANT <b>Sr. Marie Jean, 3400 S. Grand Blvd</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>Cerebral Vascular Accident</b>	<b>3 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Generalized Arterio sclerosis</b>	<b>aps.</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
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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.)
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20c. TIME OF INJURY Hour <b>11:00</b> a.m. Month, Day, Year <b>11-7-60</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>St. Louis</b>	COUNTY <b>Missouri</b>	STATE
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21. I attended the deceased from <b>11-7-60</b> to <b>11/9/1960</b> and, last saw <sup>her</sup> <b>xxx</b> alive on <b>11-7-60</b> Death occurred at <b>7:00 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>Glenn H. Sullivan M.D.</b> (D, M.D. or title)	22b. ADDRESS <b>Cardinal Glennon Hosp.</b>	22c. DATE SIGNED <b>11/10/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/11/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>
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24. FUNERAL DIRECTOR <b>Gebken Sons - 2630 Gravois Ave.</b>	25. DATE RECD. BY LOCAL REG. <b>NOV 10 1960</b>	26. REGISTRAR'S SIGNATURE <b>Glenn H. Sullivan M.D.</b>
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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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Robert J. Gibson

Licensed Embalmer No. 4444

P. O. Address 2630 Gna

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.