RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS DEC 7 1960

60-043990

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11522

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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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: 4747 Alma
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4747 Alma
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Anna Middle: Last: Mueller
4. DATE OF DEATH Month Day Year: 11/28/60
5. SEX: F
6. COLOR OR RACE: W
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 10/25/65
9. AGE (last birthday): 95
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): At Home
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: ------ Schall
13b. MOTHER'S MAIDEN NAME: ----- Hoerner
14. NAME OF HUSBAND OR WIFE: Fred Mueller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Frank Mueller, 4747 Alma

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocarditis Chronic — 6 mo
DUE TO (b) Generalized Arteriosclerosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (c) 422.1
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)

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 Oct 1st to Nov 28/60 and last saw her/him alive on 11/28/60
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): W. F. Schelling MD
22b. ADDRESS: 4724 Gravois
22c. DATE SIGNED: 11/28/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 11/30/60
23c. NAME OF CEMETERY OR CREMATORY: Our Redeemer
23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

24. FUNERAL DIRECTOR ADDRESS: John L. Ziegenhein & Sons, 7027 Gravois
25. DATE RECD. BY LOCAL REG.: NOV 30 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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