

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

S DEC 23 1960

318

1003

11868-60-042779

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)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b	c. CITY OR TOWN St. Louis.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital #1		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5 1/2 So. Broadway
3. NAME OF DECEASED (Type or print) First Oliver Middle _____ Last Mueller		4. DATE OF DEATH Month December Day 3 Year 1960	

5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/5/1918	9. AGE (last birthday) 42	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) Foundry laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Walter Mueller	13b. MOTHER'S MAIDEN NAME Ann Fey	14. NAME OF HUSBAND OR WIFE Alice	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes W.W.#2	16. SOCIAL SECURITY NO. 496-30-6550	17. INFORMANT Alice Mueller, 4319a Strodtman, Pl.	Address _____
---	---	---	---------------

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) Terminal Pneumonia, third degree burns of face and right hand, suffered when book matches ignited in hand of deceased.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Exact time and place could not be determined.	
	DUE TO (c) Accident	

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 type="checkbox"/> No <input type="checkbox"/> Unknown	
		916-9-40	

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) See above
--	--	--

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 checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) at home	20f. CITY, TOWN, OR LOCATION St Louis Mo	COUNTY _____ STATE _____
---	--	--	--------------------------

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ **3:30 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree of physician) Joseph M. Quinn	22b. ADDRESS 1200 Clark	22c. DATE SIGNED 12-12-60
--	-----------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-12-60	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.
---	------------------------------	--	---

24. FUNERAL DIRECTOR Albert H. Honpe Inc., 1700 Washington, Blvd.	25. DATE RECD. BY LOCAL REG. DEC 10 1960	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.
---	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 6 1967

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Malvin L. Kemper

Licensed Embalmer No. 4052

P. O. Address 4911 Wood
St. Louis, Mo

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.