

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

7133-62-028992
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7133

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 31 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. COUNTY St. Louis		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 St. Louis		c. CITY OR TOWN St. Louis	
Length of stay in 1b 79 yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital		d. STREET ADDRESS (If outside, give location) 5342 Arlington Ave.	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last IDA HAUB MUCHOW			4. DATE OF DEATH Month Day Year July 18, 1962
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/12/83
9. AGE (last birthday) 79 yrs.		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, Missouri
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Gustav Moll	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Albert F. W. Muchow	
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. 487-14-3234-B	
17. INFORMANT Mr. William A. Haub, 9936 Gloucester (37)		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) Cerebral Thrombosis			INTERVAL BETWEEN ONSET AND DEATH 6/25/62
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 332X			
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 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 April 17-1962 to July 18-1962 and last saw her ^{him} alive on July 18-1962 Death occurred at 5:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John G. M. Sumner M.D.		22b. ADDRESS 5014 Thekla Dr	22c. DATE SIGNED 7/20/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE July 21, 1962	23c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
24. FUNERAL DIRECTOR Beiderwieden F.H. Inc., 1936 St. Louis (6)		25. DATE RECD. BY LOCAL REG. JUL 20 1962	26. REGISTRAR'S SIGNATURE Earl Smith M.D.

Dr John B. McSwain
5014 Division
Rm 5-4688 1-5 PM
FRI

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 David [Signature]

Licensed Embalmer No. 4520

P. O. Address 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.