

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-049789

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12232 STATE FILE NUMBER

FILED DEC 20 1963

DO NOT WRITE ON THIS STUB

AMENDED

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. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Louis, Missouri</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b <u>1 week</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>7519 Cheshire Lane</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edwin</u> Middle <u>William</u> Last <u>Mueller</u>			4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>1963</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-14-1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>
13a. FATHER'S NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Arlene Mueller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>[redacted]</u>	
17. INFORMANT <u>Mr. Richard Mueller</u>		Address <u>4705 Candace Dr.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerotic heart disease</u>			<u>7 1/2 yr.</u>
DUE TO (c) <u>4200</u>			
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
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.)	
20c. TIME OF INJURY Hour <u> </u> a.m. / p.m. Month, Day, Year <u> </u>	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 <u>12-1-63</u> to <u>12-7-63</u> and last saw ^{her} him alive on <u>12-7-63</u> Death occurred at <u>2:50 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joseph A. Juppe M.D.</u>		22b. ADDRESS <u>3228 IVANHOE ST LOUIS MO</u>	
22c. DATE SIGNED <u>12-9-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-11-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
24. FUNERAL DIRECTOR <u>HOFFMEISTER COLONIAL MORTUARY</u> <u>6464 Chippewa</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 10 1963</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>

Dr. P. Swope
3228 Ivanhoe
St. L-1959
4209 Hampton
VE-2-8817

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 Linus E. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 7814 Broadway

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.

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