

FILED JUN 5 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18380
Registrar's No. 4799

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. 100

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Perry	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Tamaroa 8730	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If rural, give location) 8	

3. NAME OF DECEASED (Type or Print) a. (First) BETTY b. (Middle) JANE c. (Last) MILLER			4. DATE OF DEATH (Month) (Day) (Year) May 20, 1951			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 20, 1926	9. AGE (In years last birthday) 24	IF UNDER 1 YEAR Months Days	IF UNDER 28 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elco, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Fred Albright		13b. MOTHER'S MAIDEN NAME Lucy Jordan		14. NAME OF HUSBAND OR WIFE Bernoid Miller	
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. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Bernoid Miller, Tamaroa, Ill.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myelogenous leukemia with acute exacerbation		INTERVAL BETWEEN ONSET AND DEATH 1948
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
	DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Severe anemia and thrombocytopenia		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 2041	

22. I hereby certify that I attended the deceased from May 18, 1951, to May 20, 1951, that I last saw the deceased alive on May 20, 1951, and that death occurred at 2:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE C.O. Vermillion M.D.		23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED May 20, 1951	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-21-51		24c. NAME OF CEMETERY OR CREMATORY St. John's		24d. LOCATION (City, town, or county) (State) Mill Creek, Ill.	
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DATE REC'D BY LOCAL REG. MAY 22 1951		REGISTRAR'S SIGNATURE J.B. Sasser		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.	
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 me

.....
working under my personal supervision.

Student Embalmer No.

Signed [Signature]

Signed.....
Student Embalmer

Licensed Embalmer No. 4699

P. O. Address [Signature]

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 this body is not embalmed, fact should be so stated above.