

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35405**
8873
Registrar's No.

FILED OCT 23 1951

318

1003

BIRTH NO. REG. DIST. NO. PRIMARY REG. DIST. NO.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. CITY (If outside corporate limits, write RURAL and give township) St Louis 2159	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 4411 Gannett 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4411 Gannett			

3. NAME OF DECEASED (Type or Print) a. (First) RoeDell		b. (Middle)		c. (Last) Miller		4. DATE OF DEATH (Month) (Day) (Year) Oct. 5, 1951	
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH May 26, 1870	
9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) musician		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Indiana	
10a.		10b.		11.		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME John W Miller		13b. MOTHER'S MAIDEN NAME Aldrich		14. NAME OF HUSBAND OR WIFE Louise Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Louise Miller 4411 Gannett	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Generalized Carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 mo	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Carcinoma of the Bladder		19. 1 yr	
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) Oct 7 1951 7:00 p.m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 148X	
22. I hereby certify that I attended the deceased from Oct 7 19 51 , to Oct 5 , 19 51 , that I last saw the deceased alive on Oct 5 , 19 51 , and that death occurred at 8:00 p.m. , from the causes and on the date stated above.					

23a. SIGNATURE (Degree or title) J. H. Wagenbach M.D.		23b. ADDRESS 4717 Morganfield		23c. DATE SIGNED 10/6/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removed		24b. DATE 10/8/51		24c. NAME OF CEMETERY OR CREMATORY Kendallville, Ind.	

DATE REC'D BY LOCAL REG. OCT 8		REGISTRAR'S SIGNATURE J. E. Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS L Ziegenhein & Sons 7027 Gravois	
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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 _____

working under my personal supervision.

Student Embalmer No.

Signed Neville D. Frohwitter

Signed
Student Embalmer

Licensed Embalmer No. 3696

P. O. Address 7027 Gravois

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.