V.S. No. 300
Rev. 10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39448

BIRTH NO. _____ REG. DIST. NO. 818 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9814

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis, Missouri
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Louis City Hospital #1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis 2199
d. STREET ADDRESS (If rural, give location) 4241 Olive

3. NAME OF DECEASED (Type or Print): a. (First) CAROLINE b. (Middle) B c. (Last) MILLER
4. DATE OF DEATH (Month) NOV. (Day) 4 (Year) 1951
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Apr. abt,
9. AGE (In years last birthday) 67 — If under 1 year: Months, Days — If under 24 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) Poughkeepsie, N.Y.
12. CITIZEN OF WHAT COUNTRY? U S
13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE George
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT'S SIGNATURE OR NAME ADDRESS George Miller 4241 Olive

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Hypertensive Cardiovascular Disease

DUE TO (c) with auricular Fibrillation

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 ☑ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? H42X

22. *I hereby certify that I attended the deceased from* 11-4-51, *19*____, *to* 11-4-51, *19*____, *that I last saw the deceased alive on* 11-4-51, *19*____, *and that death occurred at* 10:10P *m., from the causes and on the date stated above.*

23a. SIGNATURE H Coleman (Degree or title)
23b. ADDRESS 1515 Lafayette Avenue
23c. DATE SIGNED 11-5-51

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-8-51
24c. NAME OF CEMETERY OR CREMATORY Calvary Cem.
24d. LOCATION (City, town, or county) St. Louis, MO. (State)

DATE REC'D BY LOCAL REG. NOV 6 1951
REGISTRAR'S SIGNATURE Earl Smith M.D.
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. HOPPE 4700 Washington

(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 Elton R. Remelius

Signed.....
Student Embalmer

Licensed Embalmer No. 4283

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