

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43177**
Registrar's No. **11192**

FILED JAN 10 1952

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (in this place) 17 OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Baptist Hospital		d. STREET ADDRESS (If rural, give location) 4204 Flad Ave.	
3. NAME OF DECEASED (Type or Print) Lavina Miller a. (First) b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Dec. 16, 1951
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Oct. 16, 1910
9. AGE (In years last birthday) 41		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) woodward Prtg. Co.	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Chas. Miller		13b. MOTHER'S MAIDEN NAME Augusta Lutz	14. NAME OF HUSBAND OR WIFE non
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 489-03-7249	17. INFORMANT'S SIGNATURE OR NAME Augusta Baum ADDRESS
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL HEMORRHAGE ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 331X	
22. I hereby certify that I attended the deceased from DEC 6, 1951 , to DEC 16, 1951 , that I last saw the deceased alive on DEC 14, 1951 , and that death occurred at 4 a.m. m., from the causes and on the date stated above.			
23a. SIGNATURE Ernest O. White (Degree or title) D. M. D.		23b. ADDRESS 1194 Hodiavon	23c. DATE SIGNED 12-17-51
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12-19-51	24c. NAME OF CEMETERY OR CREMATORY St. Lucas Cem.	24d. LOCATION (City, town, or county) (State) Sandston, Mo.
DATE REC'D BY LOCAL REG. DEC 18 1951		REGISTRAR'S SIGNATURE [Signature]	FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Southern Funeral Home 6322 S. Grand Blvd.

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

Dr. O. O. White
1194 Hodiament

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
Student Embalmer

Signed *David Van Fossan*

Licensed Embalmer, No. *4242*

P. O. Address *6322 50 Grand*

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.