

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14576**
3079
Registrar's No.

APR 25 1952

BIRTH NO. _____ 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, MISSOURI		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. Louis	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 14 4205 Washington Blvd	
d. FULL NAME OF HOSPITAL OR INSTITUTION: BARNES HOSPITAL			

3. NAME OF DECEASED (Type or Print) a. (First) DEWEY b. (Middle) NMN c. (Last) MILLER			4. DATE OF DEATH (Month) (Day) (Year) 3 30 52		
5. SEX Male		6. COLOR OR RACE COL.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH I - 12 - 1897			9. AGE (In years last birthday) 55	10. MONTHS 2	11. DAYS 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realtor		10b. KIND OF BUSINESS OR INDUSTRY Realestate		11. BIRTHPLACE (City and State or Foreign Country) Merrianna Arkansas	
12. CITIZEN OF WHAT COUNTRY? U.S.A					

13a. FATHER'S NAME Louis Miller		13b. MOTHER'S MAIDEN NAME Mattie Scruggs		14. NAME OF HUSBAND OR WIFE Theodosia Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO None		16. SOCIAL SECURITY NO. 494-07-6788		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Theodosia Miller 4205 Washington Blvd	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PULMONARY EDEMA		DUE TO (b) CARDIOVASCULAR DISEASE			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? H221	

22. I hereby certify that I attended the deceased from **3/28**, 19**52**, to **3/30**, 19**52**, that I last saw the deceased alive on **3/30**, 19**52**, and that death occurred at **3:30 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE FR Bradley (Degree or title) M.D.		23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 3/30/52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 4		24b. DATE 4/3/52		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery	
24d. LOCATION (City, town, or county) (State) ST. Louis Missouri		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John F. Houston 2829 Washington Blvd.			

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

REG. APR 2 1952
REGISTRAR'S SIGNATURE **Carl Smith M.D.**
mjs (Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

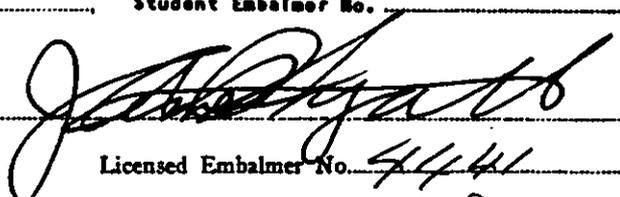
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____



Licensed Embalmer No. 4441

P. O. Address 2829 Washington

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.