

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16010**
Registrar's No. **3460**

FILED APR 18 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

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		c. LENGTH OF STAY (In this place)	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 4173 Enright Ave	
3. NAME OF DECEASED (Type or Print) Silas		a. (First)	b. (Middle)
c. (Last) Miller		4. DATE OF DEATH March 31 1953	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH October 10, 1880
9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		10b. KIND OF BUSINESS OR INDUSTRY Lenox Hotel	11. BIRTHPLACE (City and State or Foreign Country) Kentucky
12. CITIZEN OF WHAT COUNTRY? U S A		13a. FATHER'S NAME William Miller	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Delphine Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Delphine Miller		ADDRESS 4173 Enright Ave.	
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) Carcinoma of Prostate		INTERVAL BETWEEN ONSET AND DEATH Undet.	
ANTECEDENT CAUSES		DUE TO (b)	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) Pyelonephrosis - Azotemia	
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. ANEMIA	
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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR	177X
22. I hereby certify that I attended the deceased from 3-6 , 19 53 , to 3-31 , 19 53 , that I last saw the deceased alive on 3-31 , 19 53 , and that death occurred at 11:55a m., from the causes and on the date stated above.			
23a. SIGNATURE Herbert Harris (Degree or title) M. D.		23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 3-31-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4/7/53	24c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo
DATE REC'D BY LOCAL REG. APR 1 1953	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE C. W. Roberts ADDRESS 1416 N. Taylor Ave.	

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

James A. Carter

Licensed Embalmer No. *24681*

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.