

FILED JUL 31 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26699
State File No. _____
Registrar's No. 5876

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. _____		Registrar's No. 5876					
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) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>							
d. FULL NAME OF HOSPITAL OR INSTITUTION 4937 Sutherland Ave.				e. STREET ADDRESS (If rural, give location) 14 4937 Sutherland Ave. 2149									
3. NAME OF DECEASED (Type or Print) MARGARET			a. (First)		b. (Middle) A.		c. (Last) MILES		4. DATE OF DEATH (Month) (Day) (Year) June 12 1953				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH June 9, 1861		9. AGE (In years last birthday) 92		IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Kentucky			12. CITIZEN OF WHAT COUNTRY? _____				
13a. FATHER'S NAME Unknown Mueller				13b. MOTHER'S MAIDEN NAME Unknown				14. NAME OF HUSBAND OR WIFE Late Frank Mueller					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Marguerite McCalpin 4937 Sutherland							
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerosis Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>unk</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis generalized</u> <u>unk</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes Mellitus</u> <u>10 years</u>											
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>4200</u>									
22. I hereby certify that I attended the deceased from <u>Dec 1947</u> , to <u>JUNE 12, 1953</u> , that I last saw the deceased alive on <u>June 11, 1953</u> , and that death occurred at <u>8:00A</u> m., from the causes and on the date stated above.													
23a. SIGNATURE <u>Robert G. Warner</u> (Degree or title) <u>MD.</u>				23b. ADDRESS <u>510 Olive St St Louis Mo</u>				23c. DATE SIGNED <u>12 June 53</u>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jun. 15, 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>							
DATE REC'D BY LOCAL REG. JUN 12 1953		REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u>				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Kriegshauser 4228 S. Kingshighway Bl.</u>							

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Richard W. Storey*

Licensed Embalmer No. *400*

P. O. Address

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.