

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **44574**

FILED DEC 29 1953

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 531 Registrar's No. 3194

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>University City</u>		c. CITY OR TOWN <u>University City</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>11 yrs.</u>		e. STREET ADDRESS (If rural, give location) <u>7947 Gannon Avenue</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>7947 Gannon Avenue</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>WILMA</u>	b. (Middle) <u>RUSSELL</u>	c. (Last) <u>MILLER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>12 15 53</u>
-------------------------------------	-------------------------	----------------------------	-------------------------	---

5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept. 10, 1900</u>	9. AGE (In years last birthday) <u>53</u>	IF UNDER 1 YEAR Months _____	IF UNDER 1 YEAR Days _____	IF UNDER 1 HRS. Hours _____	IF UNDER 1 HRS. Mins. _____
----------------------	-------------------------------	---	--	---	------------------------------	----------------------------	-----------------------------	-----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Harrisonville, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
--	--	---	---

13a. FATHER'S NAME <u>Will Russell</u>	13b. MOTHER'S MAIDEN NAME <u>Della Vanderventer</u>	14. NAME OF HUSBAND OR WIFE <u>Ray E. Miller</u>
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Ray E. Miller, 7947 Gannon Avenue</u>
--	-------------------------------------	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Reticulum cell sarcoma</u>		<u>2 yr. 7 mo.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>none</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Radical mastectomy, cancer of breast, 1949 cured.</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>2000</u>
--	--	---

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? _____
---	--	----------------------------------

22. I hereby certify that I attended the deceased from May 3, 1951, to Dec. 15, 1951, that I last saw the deceased alive on Dec. 14, 1953, and that death occurred at 1 A. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Edward H. Reinhard M.D.</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>4960 Audubon Ave. St. Louis Mo</u>	23c. DATE SIGNED <u>12-15-53</u>
---	-------------------------------	--	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	24b. DATE <u>12-16-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Orient Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Harrisonville, Missouri</u>
--	---------------------------	---	--

DATE REC'D BY LOCAL REG. <u>12-15-53</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Dombke M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C. R. Lupton & Sons-7233 Delmar Blv'd.,</u>
--	---	---

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

MAR 11 1955

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..... *Arnold W. Schoene*

Licensed Embalmer No. *3864*

P. O. Address. *St. Louis.*

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.