

FILED AUG 12 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25561

BIRTH NO. --- REG. DIST. NO. 517 PRIMARY REG. DIST. NO. 541 Registrar's No. 1575

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Clayton</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. John 4201</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis County Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>2986 Kincaid</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Gilbert</b> b. (Middle) <b>Miller</b> c. (Last) <b>Miller</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>July 2 1954</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>Sept 5 1900</b>		9. AGE (In years last birthday) <b>53</b>		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Body Maker</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Indiana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					

13a. FATHER'S NAME <b>George Miller</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Kelley</b>		14. NAME OF HUSBAND OR WIFE <b>Myrtle Evans Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W. I</b>		16. SOCIAL SECURITY NO. <b>494-10-3692</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Myrtle Miller</b> ADDRESS <b>2986 Kincaid</b>	

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) <b>Carcinoma of Lung</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 yrs</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) _____ 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 <b>5/16/54</b>		19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of Lung 163X</b>			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?		

22. I hereby certify that I attended the deceased from **6/29 1954**, to **7/2 1954**, that I last saw the deceased alive on **7/2 1954**, and that death occurred at **4:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>W. A. Miller</b> (Degree or title)		23b. ADDRESS <b>89 24 St. Charles Rd. St. Louis 14 Mo.</b>		DATE SIGNED <b>7/2/54</b>	
24a. BURIAL: CREMA-TION REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>July 5 1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetery</b>	
				24d. LOCATION (City, town, or county) (State) <b>St. Clair Mo.</b>	

DATE REC'D BY LOCAL REG. <b>7/14/54</b>		REGISTRAR'S SIGNATURE <b>Harold R. Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Miller Mortuary</b> ADDRESS <b>10123 St. Chas. Rd</b>	
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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 .....  
Student Embalmer

Signed

*Sheldon Collier*

Licensed Embalmer No. 3382

P. O. Address 1012 3 St. Chas

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.