

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 30 1954

318

1003

Registrar's No. 10908

BIRTH NO. 92438-54 REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) Berkeley 4091	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital		d. STREET ADDRESS (If rural, give location) 8830 Harold Drive.	

3. NAME OF DECEASED a. (First) Infant b. (Middle) - - - c. (Last) Miller			4. DATE OF DEATH (Month) (Day) (Year) Nov. 28, 1954.		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Nov. 28, 1954	9. AGE (In years last birthday) 0	IF UNDER 1 YEAR Months 0 Days 0 Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Charles G. Miller	13b. MOTHER'S MAIDEN NAME Margaret E. Thorp	14. NAME OF HUSBAND OR WIFE - - -
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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 Charles G. Miller, 8830 Harold Dr.	ADDRESS
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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) Anoxia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pulmonary Immaturity DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Premature birth - 20mg gestation		INTERVAL BETWEEN ONSET AND DEATH
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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? 7625
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22. I hereby certify that I attended the deceased from 11:28, 1954, to 11:28, 1954, that I last saw the deceased alive on 11-28, 1954, and that death occurred at 10:00P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Chas. J. Smith, M.D.	23b. ADDRESS 6000 W. Flouissant	23c. DATE SIGNED 11-29-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 11/30/54.	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REG. NOV 30 1954	REGISTRAR'S SIGNATURE Charles Smith MO	25. FUNERAL DIRECTOR'S SIGNATURE Calvin F. Feutz, 4828 Natural Bridge Blvd.	ADDRESS
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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 *John A. Miller*

Licensed Embalmer No. *4186*

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.