

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17280

State File No. ....

FILED MAY 17 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 548 Registrar's No. 1020

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Webster Groves</b>		c. CITY OR TOWN <b>Webster Groves</b> <sup>40</sup> <sub>17</sub>	
c. LENGTH OF STAY (in this place) <b>65 Yrs</b>		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 <b>653 Tuxedo</b>		STREET ADDRESS (If rural, give location) <b>653 Tuxedo</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>ALBERTINE</b>	b. (Middle) <b>HULL</b>	c. (Last) <b>MILLER</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>5-3-1955</b>
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5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>12-7-1872</b>	9. AGE (In years last birthday) <b>82</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Schodack Landing, N.Y.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>William S Hull</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah B Fitch</b>	14. NAME OF HUSBAND OR WIFE <b>F. Benton Miller</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. J.H. Spencer</b>	ADDRESS <b>653 Tuxedo</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yr</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Adenocarcinoma of sigmoid colon</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Metastasis to liver</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>Nov. 1953</b>	19b. MAJOR FINDINGS OF OPERATION <b>Adenocarcinoma of sigmoid colon</b>	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) <b>153X</b>
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?

22. I hereby certify that I attended the deceased from July, 19 54 to May 2, 19 55, that I last saw the deceased alive on MSR 2, 19 55, and that death occurred at 7 on 5-3-1955 from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>J. H. Spencer, M.D.</b>	23b. ADDRESS <b>19 E. Lockwood W.G., Mo.</b>	23c. DATE SIGNED <b>5-4-1955</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>5-5-1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Kirkwood Mo.</b>
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DATE REC'D BY LOCAL REG. <b>5/5/55</b>	REGISTRAR'S SIGNATURE <b>Herbert R. Donke, M.D.</b>	FUNERAL DIRECTOR'S SIGNATURE <b>Harper Aldrich F. Home</b>	ADDRESS <b>Webster Groves</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

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JAN 24 1957

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 *Leslie Welch*

Licensed Embalmer No. *43*  
P. O. Address *Holston, Ga*

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.