

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32264**
8229

FILED SEP 26 1956

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Missouri			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 2 hours	c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Chronic Hospital			e. STREET ADDRESS (If rural, give location) 3125 Delmar		
3. NAME OF DECEASED (Type or Print) Henrietta Miller		a. (First) _____ b. (Middle) _____ c. (Last) _____	4. DATE OF DEATH 8/30/56		(Month) (Day) (Year)
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 4/20/04	9. AGE (In years last birthday) 52	# UNDER 1 YEAR Months 4 Days 10
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) Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Will Jackson		13b. MOTHER'S MAIDEN NAME Ida St. Clair		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Chronic Hospital, 5600 Arsenal		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) INTERCURRENT CAUSES *This does not mean the mode of dying, such as heart failure, asphyxiation, etc. It means the disease, injury, or complication which caused death. 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolism (b) Hypertensive Cardiovascular Disease (c) Disease 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 hr. yes.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 443 x			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 8/30 , 19 56 , to 8/30 , 19 56 , that I last saw the deceased alive on 8/30 , 19 56 , and that death occurred at 3:50 P.M. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) George M. Tanaka, M.D.			23b. ADDRESS 5600 Arsenal Street		23c. DATE SIGNED 8/31/56
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9/6/56	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) Berkeley Mo		
DATE REC'D BY LOCAL REG. SEP 6 1956		REGISTRAR'S SIGNATURE Charles Smith	FUNERAL DIRECTOR'S SIGNATURE E. B. Koonce		ADDRESS 1221 N. Grand

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

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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.....
Jessie A. ...

Licensed Embalmer No. *6775*

P. O. Address *122 no. Dr*

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.