

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43546

FILED JAN 15 1957

STATE FILE NUMBER

318

1003

REGISTRAR'S NO. 11637

Registration District No. Primary Registration District No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>SAINT LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		Length of stay in 1b	d. STREET ADDRESS <b>2217 2847 Delmar</b>		(If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Charlie</b> Middle <b>Miller</b> Last <b>Miller</b>			4. DATE OF DEATH Month <b>12</b> Day <b>15</b> Year <b>56</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 10, 1911</b>	9. AGE (In years last birthday) <b>45</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>13</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and state or country) <b>MISSISSIPPI</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>MR. CHARLEY MILLER</b>			14. MOTHER'S MAIDEN NAME <b>MARY BARNES</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>190-36-5042</b>		17. INFORMANT Address <b>MRS MARIA MILLER 3929a FINNEY AVE.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Insufficiency</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) <b>Hypertensive Cardiovascular Disease</b>
					DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uremia - Arteriolar nephrosclerosis, - Bronchopneumonia, Confluent</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>442x</b>		
20c. TIME OF INJURY Hour <b></b> Month <b></b> Day <b></b> Year <b></b> a. m. <b></b> p. m. <b></b>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>12-4-56 10:45</b> P. to <b>12-15-56</b> and last saw <del>him</del> <sup>xxx</sup> alive on <b>12-15-56</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Hugh R. Waters, M.D.</b>			22b. ADDRESS <b>2601 Whittier Street</b>		22c. DATE SIGNED <b>12-18-56</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>12-20-56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON PARK</b>		23d. LOCATION (City, town, or county) (State) <b>BERKLEY CITY MO.</b>
24. FUNERAL DIRECTOR <b>Mr. C. B. House 1221 N. GRAND</b>			25. DATE RECD. BY LOCAL REG. <b>DEC 19 1956</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b> <b>m &amp; B.</b>

(Licensed Embalmer's Statement on Reverse Side)

000-56  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms were observed. AT  
diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

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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.....  


Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
(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.