

FILED MAR 18 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10745

STATE FILE NUMBER

1642

Registration District No. **318** Primary Registration District No. **1003** Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</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>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1</b>		Length of stay in lb <b>9 26</b>	d. STREET ADDRESS (If outside, give location) <b>3607 N. 20th</b>
3. NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>H.</b> Last <b>MILLER</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>16</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-5-1886</b>
9. AGE (In years last birthday) <b>70</b>	IF UNDER 1 YEAR Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Kiel Auditorium</b>
11. BIRTHPLACE (City and state or country) <b>New Albany Ind 1</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Miller</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Mc Kinney</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>488-05-7451</b>	17. INFORMANT <b>Hattie Miller - 3607 N. 20th</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>PERITONITIS</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>EXTRAVASATED CONTENT OF VISCERA -</b> DUE TO (c) <b>POST OPERATIVE TOTAL COLECTOMY FOLLOWING MASSIVE LOWER GASTROINTESTINAL BLEEDING</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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>578x</b>		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.	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>1-30-57</b> to <b>2-16-57</b> and last saw her alive on <b>2-16-57</b> Death occurred at <b>1:49 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>John Allen Burrell (M.D.)</b>		22b. ADDRESS <b>1515 LAFAYETTE</b>	22c. DATE SIGNED <b>2-17-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>2-20-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Friederichs Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
24. FUNERAL DIRECTOR <b>Edw Kodz &amp; Son - 3516 S. 14th</b>		25. DATE RECD. BY LOCAL REG. <b>FEB 18 '57.</b>	26. REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>

(Licensed Embalmer's Statement on Reverse Side)

S.P.

S. 300  
y. 1-56

securing the medical certification in the specific manner required by 193.140-MO-RS-1747.  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

8091

813

ST. LOUIS

ST. LOUIS  
MISSOURI

TO

FROM

RELATION

EXPIRES

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 *Loren E. Perry*  
Licensed Embalmer No. 409

P. O. Address *St. Louis*

12-21-5

12-21-5

12-21-5

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.