

19069

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

318

1003

Registrar's No.

No. 300

10.48

FILED JUN 14 1957

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 5312	
1. PLACE OF DEATH a. COUNTY _____				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 town) St. Louis		c. LENGTH OF STAY (If this place) 15 years		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 Deaconess Hospital				e. STREET ADDRESS (If rural, give location) 4420a Floriss Place, 15,			
3. NAME OF DECEASED (Type or Print) a. (First) HAYES		b. (Middle) N.		c. (Last) MILLER		4. DATE OF DEATH (Month) (Day) (Year) June 5th, 1957	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Feb. 27th, 1877	
9. AGE (10 years last birthday) 80		IF UNDER 1 YEAR (Months) (Days)		IF UNDER 12 HRS. (Hours) (Mins.)			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired RR Conductor		10b. KIND OF BUSINESS OR INDUSTRY Rock Island		11. BIRTHPLACE (City and State or Foreign Country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Nicholas Miller		13b. MOTHER'S MAIDEN NAME Barbara Stahl		14. NAME OF HUSBAND/OR WIFE Maude D. Miller nee Sewell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Maude D. Miller, 4420a Floriss Place, 15			
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis, right ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis DUE TO (c) _____ 2. OTHER SIGNIFICANT CONDITIONS Arteriosclerotic heart disease with all blood supply of left ventricle Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 5 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 332x				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
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 Oct 1 , 19 56 , to present , 19____, that I last saw the deceased alive on June 4 , 19 57 , and that death occurred at 9:45A m., from the causes and on the date stated above.							
23a. SIGNATURE Robert E. Hengland MD				23b. ADDRESS (Degree or title) 14 FORSYTH WALK CLAYTON 5, MO		23c. DATE SIGNED June 6, 1957	
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 6/8/57		24c. NAME OF CEMETERY OR CREMATORY Memorial Park		24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	
DATE REC'D BY LOCAL HEALTH DEPT. JUN 6 57		REGISTRAR'S SIGNATURE K. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE CALVIN F. FEUTZ ADDRESS 4828 Natural Bridge Blvd., St. Louis, 15, Missouri.			

(Licensed Embalmer's Statement on Reverse Side)

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..... Signature of Student Embalmer

Signed..... *Ralph C. Linders*.....

Licensed Embalmer No..... 427.....

P. O. Address..... *St. Louis*.....

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.