

FILED SEP 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29786

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7626

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 township) OR TOWN St Louis c. LENGTH OF STAY (in this place) _____ c. CITY OR TOWN St Louis d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 30 Saint Louis Maternity e. STREET ADDRESS (If rural, give location) 7270 1236 North Kingshighway

3. NAME OF DECEASED a. (First) _____ b. (Middle) _____ c. (Last) Miller 4. DATE OF DEATH (Month) (Day) (Year) August 6 1957

5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____ 8. DATE OF BIRTH July 15 1957 9. AGE (In years last birthday) 21 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and State or Foreign Country) St Louis Missouri 12. CITIZEN OF WHAT COUNTRY? _____

13a. FATHER'S NAME Adam Miller 13b. MOTHER'S MAIDEN NAME Ollie Mae Gray 14. NAME OF HUSBAND OR WIFE _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT'S SIGNATURE OR NAME Ollie Mae Miller ADDRESS Above

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) BRONCHIAL PNEUMONIA INTERVAL BETWEEN ONSET AND DEATH 5 days

*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Prematurity 20 days DUE TO (c) 763.5

II. OTHER SIGNIFICANT CONDITIONS Peritonitis

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES 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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from July 15, 1957, to August 6, 1957, that I last saw the deceased alive on August 6, 1957 and that death occurred at 2:20 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Homer E. Nash Jr. M.D. 23b. ADDRESS 3136 Easton Ave 23c. DATE SIGNED 8/9/57

24a. BURIAL, CREMATION, REMOVAL (Specify) _____ 24b. DATE 8-31-57 24c. NAME OF CEMETERY OR CREMATORY Anatomical Board 24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. AUG 15 57 REGISTRAR'S SIGNATURE Carl Smith M.D. 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland-Likes 4104 Manchester

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.....

Licensed Embalmer No.....

P. O. Address.....

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.