

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 30 1957

State File No. 29789
Registrar's No. 7276

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. 29789		Registrar's No. 7276			
1. PLACE OF DEATH a. COUNTY _____					2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			c. LENGTH OF STAY (in this place) 1 week		c. CITY OR TOWN 4009 Webster Groves		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 08 Deaconess Hospital					e. STREET ADDRESS (If rural, give location) 27 425 Oak Street						
3. NAME OF DECEASED (Type or Print) a. (First) DR. H.			b. (Middle) EDWARD		c. (Last) MILLER		4. DATE OF DEATH (Month) (Day) (Year) August 3rd, 1957				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Feb. 1st, 1878		9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician			10b. KIND OF BUSINESS OR INDUSTRY Ear, Nose & Throat		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri			12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Herman Miller			13b. MOTHER'S MAIDEN NAME Dorothea VonHaaren			14. NAME OF HUSBAND OR WIFE June Oehler Miller					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Theodore S. Cleveland 425 Oak St.						
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARDIAC INSUFFICIENCY ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) MITRAL STENOSIS DUE TO (c) RHEUMATIC HEART DISEASE, INACTIVE II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 410X					INTERVAL BETWEEN ONSET AND DEATH 1 WK. UNKNOWN UNKNOWN	
19a. DATE OF OPERATION _____			19b. MAJOR FINDINGS OF OPERATION _____			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 <u>Jan. 29, 1953</u> , to <u>Aug. 3, 1957</u> , that I last saw the deceased alive on <u>Aug. 2, 1957</u> , and that death occurred at <u>4:30 a.m.</u> , from the causes and on the date stated above.											
23a. SIGNATURE <i>Robert E. Koch</i> (Degree or title) M.D.					23b. ADDRESS 35 N. Central, Clayton, Mo.			23c. DATE SIGNED 8-3-57			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8 / 5 / 57		24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri					
DATE REC'D BY LOCAL REG. AUG 5 '57		REGISTRAR'S SIGNATURE <i>Carl Smith</i>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. R. Lupton & Sons 7233 Delmar Bl.						

(Licensed Embalmer's Statement on Reverse Side)

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

JUL 17 1958

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... *Arnold W. Schoen*

Licensed Embalmer No. *386*

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.