

pt. Health,  
& Welfare  
S. Public  
Hlth. Service

7. 300  
ev. 1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42359

STATE FILE NUMBER

FILED NOV 22 1957

Registration District No. 318

318

Primary Registration District No. 1003

1003

Registrar's No. 10477

10477

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS Maplewood</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VET ADM HOSPITAL</u>			Length of stay in lb <u>10 DAYS</u>	d. STREET ADDRESS <u>2286 YALE</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>WESLEY</u> Middle <u>R</u> Last <u>MILLER</u>				4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>57</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-19-16</u>		9. AGE (In years last birthday) <u>41</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>TV - Radio</u>		11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>RICHARD MILLER</u>			13b. MOTHER'S MAIDEN NAME <u>EFFIE WILLIAMS</u>			14. NAME OF HUSBAND OR WIFE <u>ADELE MILLER</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WW 2</u>			16. SOCIAL SECURITY NO. <u>493-01-6869</u>		17. INFORMANT Address <u>VA HOSP RECORDS, 915 N GRAND ST LOUIS MO.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPIRATION OF BLOOD</u>							INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>MASSIVE UPPER GASTRO-INTESTINAL HEMORRHAGE</u>				UNKNOWN	
			DUE TO (c) <u>CIRRHOSIS OF LIVER</u>				UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>581.0</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)					
20c. TIME OF INJURY Hour <u>  </u> Month, Day, Year a.m. <u>  </u> p.m. <u>  </u>								
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>VA 10-24-57</u> to <u>11-3-57</u> and last saw him live on <u>11-3-57</u> Death occurred at <u>4:45 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Frank M. Bennett</u> (Degree or title) <u>M. D.</u>			22b. ADDRESS <u>VAH. ST. LOUIS, MO.</u>			22c. DATE SIGNED <u>11-3-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>11-6-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Jefferson Bks. Mo.</u>			
24. FUNERAL DIRECTOR <u>JAY B. SMITH, Maplewood, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>NOV 5 '57</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MO</u> <u>mjb</u>			

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. 4029

P. O. Address Maplewood

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.