

FILED DEC 9 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

423861

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10771**

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, give TOWNSHIP only) St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Clayton 44520		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) 32 HOSPITAL OR INSTITUTION St. Luke's Hosp.			Length of stay in lb 7 weeks		d. STREET ADDRESS (If outside, give location) 27 7628 Maryland Avenue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MILDRED Middle KUSTER Last MILLICE				4. DATE OF DEATH Month November Day 12, Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1882		9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Plateville, Wisconsin		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Kuster				14. MOTHER'S MAIDEN NAME Katherine Nichol			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Carl T. Millice 7628 Maryland Ave.			
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>Uremia</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Diabetes mell. & Hypertension + arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (g) <u>Left hemiparesis due to thrombosis cerebral Co. 260+</u>							INTERVAL BETWEEN ONSET AND DEATH 2 Mo yrs yrs
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 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 <u>2/21/55</u> to <u>12 NOV 57</u> and last saw ^{her} _{him} alive on <u>11 NOV 57</u> Death occurred at <u>2:40 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Raymond Millice</u> M.D.				22b. ADDRESS <u>114 NO Taylor St. Louis 8 MO</u>		22c. DATE SIGNED <u>12 NOV 57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>11-14-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>C. R. Lupton & Sons 7233 Delmar</u>			25. DATE RECD. BY LOCAL REG. <u>NOV 12 '57</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>		

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. Ray Williams
114 North Taylor
Jefferson 3-8600
Hours _____

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. Schoene*

Licensed Embalmer No. *3864*

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.