

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JAN 13 1958

3321

STATE FILE NUMBER

63

Registration District No. **318**

**318**

Primary Registration District No. **1003**

**1003**

Registrar's No.

300

-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis 4009</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Ferguson</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Christian Hospital</b>		Length of stay in lb <b>3 weeks</b>	STREET ADDRESS (If outside, give location) <b>229 North Schlueter</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>J.</b> Last <b>Miller</b> <b>Florence Miller</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>3,</b> Year <b>1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 1, 1913</b>
9. AGE (In years) <b>44</b> IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>unknown</b>	
13b. MOTHER'S MAIDEN NAME <b>Julia Boland</b>		14. NAME OF HUSBAND OR WIFE <b>Lester W. Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>491-14-4958</b>	
17. INFORMANT <b>Lester W. Miller, 229 N. Schlueter</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Dilatation</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Splenomyelogenous Leukemia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hours</b> <b>2 months</b> <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <b>204.1</b>	
20c. TIME OF INJURY: Hour <input type="checkbox"/> Month, Day, Year <input type="checkbox"/>			
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 <b>Jan. 1932</b> to <b>Jan. 3, 1958</b> and last saw her/him alive on <b>Jan. 2, 1958</b> Death occurred at <b>4:00 AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Robert C. McElwain M.D.</b>		22b. ADDRESS <b>4356 Warne Avenue (7)</b>	
22c. DATE SIGNED <b>1-3-58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan. 6, 1958</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Friedens Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>	
24. FUNERAL DIRECTOR <b>Math Hermann &amp; Son, Inc., 2161 E. Fair</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 4 '58</b>	
26. REGISTRAR'S SIGNATURE <b>J. Carl Smith me</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Allen W. Noy* .....

Licensed Embalmer No. *2373*  
P. O. Address *St. Louis, Mo.*

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.