

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-008184  
STATE FILE NUMBER

FILED MAR 12 1958

Registration District No. 317 Primary Registration District No. 545 Registrar's No. 646

300  
-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Maplewood</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Richmond Heights</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Maplewood Nursing Home</b>		Length of stay in 1b <b>8 mos.</b>	d. STREET ADDRESS (If outside, give location) <b>1612 Hunter</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Ray</b> Middle <b>Allen</b> Last <b>Miller</b>			4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>1958</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 12, 1888</b>		9. AGE (In years last birthday) <b>70yrs</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done in greatest of working life, even if retired) <b>Retired Div. Mgr. Standard Oil</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Vanderbergh Co., Ind.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Jess Miller</b>		13b. MOTHER'S MAIDEN NAME <b>Susan Mae</b>		14. NAME OF HUSBAND OR WIFE <b>Pauline Seibert 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 None</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. Marian Fawley 1612 Hunter (17)</b>		
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>Pneumonia, right lower lobe</b>					INTERVAL BETWEEN ONSET AND DEATH <b>About 7 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<b>490X</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic Heart Disease</b>					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.)			
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <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>Feb 1, 1958</b> to <b>March 2, 1958</b> and last saw him alive on <b>March 2, 1958</b> Death occurred at <b>6:05 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>James B Jones M.D.</b>			22b. ADDRESS <b>337 W. Lockwood Webster Groves 19 Mo.</b>		22c. DATE SIGNED <b>3-2-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>March 4, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Locus Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Evansville, Ind.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Alexander &amp; Sons 6175 Delmar</b>		25. DATE RECD. BY LOCAL REG. <b>3-3-58</b>		26. REGISTRAR'S SIGNATURE <b>Herbert R. Donke M.D.</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in which to no symptoms or diseases in Part I must be causally related.

Dr. J. B. Jones  
9335 Sonora  
No 2-3462  
1111 No of Fitzinger  
The Paragon  
2 P.M.

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 *Jos. E. McCulloch* .....

Licensed Embalmer No. *2460* .....

P. O. Address *6170 2nd St* .....

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.