

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-027247

STATE FILE NUMBER

1003

Registrator's No. 6292

FILED JUL 18 1958

Registration District No.

318

Primary Registration District No.

5. 300  
1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>St Louis</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>Maryland Hgts 4000</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo Bapt Hoosp</b>		Length of stay in lb <b>1 mo</b>	d. STREET ADDRESS (If outside, give location) <b>27 Mueller Lane</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Chalmer E Miller</b>			4. DATE OF DEATH Month Day Year <b>June 19 1958</b>		
5. SEX <b>Male</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>Nov 16 1896</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <b>61</b> Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>A C I C</b>	11. BIRTHPLACE (City and state or country) <b>Malden Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Franklin Miller</b>		13b. MOTHER'S MAIDEN NAME <b>Aggie Stacy</b>		14. NAME OF HUSBAND OR WIFE <b>Amy L Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes W W # 1</b>		16. SOCIAL SECURITY NO. <b>495-12-8698</b>		17. INFORMANT Address <b>Amy L Miller Maryland Hgts Mo</b>	
18. CAUSE OF DEATH (Enter only one cause possible for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in Part I (a) <b>420.0</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b> <b>4 mos</b>	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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>March 7 '58</b> to <b>June 19 '58</b> and last saw him alive on <b>June 14 1958</b> Death occurred at <b>9:10 AM</b> (Use the date stated above; and to the best of my knowledge, from the causes stated.)					
22a. SIGNATURE (Degree or title) <b>Richard G. Jones MD</b>			22b. ADDRESS <b>3720 Washington</b>		22c. DATE SIGNED <b>June 20 '58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>5/21/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Laquey Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Laquey, Pulaski Co Mo</b>
24. FUNERAL DIRECTOR ADDRESS <b>Ortmann F Home 9222 Lackland</b>			25. DATE RECD. BY LOCAL REG. <b>JUN 20 '58</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith Mo</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

Overland Mo

(Licensed Embalmer's Statement on Reverse Side)

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 Al C. Ostmann .....

Licensed Embalmer No. 3478 .....

P. O. Address Overland 147 .....

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.