

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031247

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 543 Registrar's No. 2110

1. PLACE OF DEATH
a. COUNTY ST. LOUIS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Jennings Inside Limits Yes No

c. CITY OR TOWN ST LOUIS Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2551 Oakcrest Length of stay in lb 1-Mo 22 2/3

d. STREET ADDRESS (If outside, give location) 1124 Destrehan Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Louis Middle W. Last Miller

4. DATE OF DEATH Month 8 Day 11 Year 58

5. SEX M

6. COLOR OR RACE W

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH 8/9/1892

9. AGE (In years last birthday) 66 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) glass worker

10b. KIND OF BUSINESS OR INDUSTRY glass mfg.

11. BIRTHPLACE (City and state or country) ST LOUIS

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Jacob Miller

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE Viola A. Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 492-104796

17. INFORMANT Address Hazel Bridges-2551 Oakcrest

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CARCINOMA, STOMACH
DUE TO (c) 151X

INTERVAL BETWEEN ONSET AND DEATH
4-6 mo.
6-8 mo.

20a. ACCIDENT SUICIDE HOMICIDE

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 NOT WHILE AT WORK

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 7-10-58, to 8-6-58 and last saw him alive on 8-6-58
Death occurred at 9:15 a. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Leo F. Donley M.D.

22b. ADDRESS 2759 N. Grand

22c. DATE SIGNED 8-11-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 8/14/58

23c. NAME OF CEMETERY OR CREMATORY Calvary

23d. LOCATION (City, town, or county) (State) ST. LOUIS, MO.

24. FUNERAL DIRECTOR ADDRESS Edw. Koch + Son - 3176 N 14th St

25. DATE RECD. BY LOCAL REG. 8-13-58

26. REGISTRAR'S SIGNATURE Herbert P. Donke M.D.

Medical Certification
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
physician, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *Hustar W. Sieten*

Licensed Embalmer No. *4371*

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.