

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034956

STATE FILE NUMBER

1100 SEP 22 1958 Registration District No. 317 Primary Registration District No. 543 Registrar's No. 2216

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> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Jennings</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</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>2551 Oakcrest</b>		Length of stay in 1b <b>3 MONTHS 22 1958</b>	
3. NAME OF DECEASED (Type or print) <b>Viola A. Miller</b> First Middle Last		4. DATE OF DEATH <b>8-23-1958</b> Month Day Year	
5. SEX <b>F</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>5-8-1900</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	9c. AGE (In years last birthday) <b>58</b> 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) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	10c. BIRTHPLACE (City and state or country) <b>Desoto, Mo</b>
11. BIRTHPLACE (City and state or country) <b>Desoto, Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Hussman</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>495-16-8724</b>	17. INFORMANT <b>Hazel Bridges-2551 Oakcrest</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>Generalized carcinomatosis</b> DUE TO (b) <b>Brechyrogenis Carcinoma</b> DUE TO (c) <b>162.1</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b> <b>6 mo.</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 <b>Hour Month, Day, Year</b>	
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>2-1-58</b> to <b>8-22-58</b> and last saw <sup>her</sup> alive on <b>8-22-58</b> Death occurred at <b>3:30 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Dr James D. O. 2</b>		22b. ADDRESS <b>12000 Bellefontaine Rd</b>	22c. DATE SIGNED <b>8-25-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-26-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b>
24. FUNERAL DIRECTOR <b>Edw Kochosan - 3516 N. 14th</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>8-25-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Donke M.D.</b>

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service

300 1-56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

MEDICAL CERTIFICATION

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: *Gustav W. Scilene*

Licensed Embalmer No. *43*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.