

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038036

STATE FILE NUMBER

FILED OCT 30 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9840

5. 300
1-57
3

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>388 Route City Hospital</u>			Length of stay in 1b <u>4239</u>		d. STREET ADDRESS (If outside, give location) <u>2622 Allen Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Leo</u> Last <u>Mills</u>				4. DATE OF DEATH Month <u>October</u> Day <u>13</u> Year <u>1958</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 4, 1897</u>		9. AGE (In years at birthday) <u>61</u> 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) <u>Night Watchman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (City and state or country) <u>Kentucky /</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13a. FATHER'S NAME <u>James Mills</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Unavailable</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <u>no</u> , or unknown) (If yes, give year or dates of service) <u>Yes WW I</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Mary Goshen, Little Rock, Ark.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), starting the under- lying cause last. } DUE TO (b) _____									
DUE TO (c) _____ <u>420-1</u>									
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 checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. _____									
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 _____ to _____ and last saw ^{her} _{him} alive on _____ Death occurred at _____ m. on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE, <u>Patricia J. Taylor</u> (Degree or title) <u>3</u>				22b. ADDRESS <u>1300 Clark</u>				22c. DATE SIGNED <u>10 14 58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10-14-58</u>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) <u>Brandenburg, Ky.</u> (State)			
24. FUNERAL DIRECTOR <u>Albert H. Hoppe, 4700 Washington Blvd.</u>				25. DATE RECD. BY LOCAL REG. <u>OCT 14 58</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>			

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 *J. Wm. Dunkley*

Licensed Embalmer No. *3653*

P. O. Address *J. Lewis & Co.*

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.