THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004007
STATE FILE NUMBER

FILED FEB 4 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 243

1. PLACE OF DEATH
a. COUNTY: St Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kocit Mo — Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Robt Koch Hosp — Length of stay in 1b: 216 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY:
c. CITY OR TOWN: St Louis 2119 — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 4342 COTTAGE — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle Last MILLER
4. DATE OF DEATH: Month JAN Day 22 Year 1959
5. SEX: M 2
6. COLOR OR RACE: N
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH: About 1883
9. AGE (In years last birthday): 76 ?
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): NIL
10b. KIND OF BUSINESS OR INDUSTRY: NIL
11. BIRTHPLACE (City and state or country): NORTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: GRANVILLE MILLER
14. MOTHER'S MAIDEN NAME: ABBIE ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: lost
17. INFORMANT: Hospital and Address: Robert Koch Hosp. Koch Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Fibrocaseous tuberculosis with cavities
DUE TO (c): 008A
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 ☒ NO ☐

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 a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED: WHILE AT WORK ☐ 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 JUNE 20/58 to JAN 22/59 and last saw him alive on Jan 22/59
Death occurred at 2:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Frank Cohen (Degree or title) MD
22b. ADDRESS: Robert Koch Hosp Koch Mo
22c. DATE SIGNED: Jan 22/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 1/28/59
23c. NAME OF CEMETERY OR CREMATORY: Washington Park Cem.
23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

24. FUNERAL DIRECTOR: Charles J. Cates ADDRESS: 4107 Finney
25. DATE RECD. BY LOCAL REG.: 1-26-59
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Guyton Swa

Licensed Embalmer No. 45

P. O. Address 4107 Fin

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.