

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015431

STATE FILE NUMBER

2 3735

FILED MAY 6 1959 Registration District No. Primary Registration District No. Registrar No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cape Girardeau	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Cape Girardeau	
c. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 834 Merriweather	
3. NAME OF DECEASED (Type or print) First Middle Last WALDO B. MILLER		4. DATE OF DEATH Month Day Year APRIL 13, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-13-1909
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		9b. KIND OF BUSINESS OR INDUSTRY Contractor	9c. AGE (In years last birthday) 49
10a. FATHER'S NAME William Miller		10b. MOTHER'S MAIDEN NAME Marietta Hawkins	10c. NAME OF HUSBAND OR WIFE Eva Mae Miller
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		12. SOCIAL SECURITY NO. 333-10-6372	13. INFORMANT Address Eva Miller, Cape Girardeau, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE GASTROINTESTINAL HEMORRHAGE DUE TO (b) ESOPHAGEAL VARICES DUE TO (c) LAENNEC'S CIRRHOSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) RENAL FAILURE DUE TO HEPATORENAL SYNDROME			INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 2 YEARS 5 YEARS 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 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 APRIL 8, 1959 to APRIL 13, 1959 and last saw her/him alive on APRIL 13, 1959 Death occurred at 12:20 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) C. O. Vermillion, M.D.		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 4/13/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 4-15-1959	23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR ADDRESS Walthers, Cape Girardeau, Mo.		25. DATE RECD. BY LOCAL REG. APR 15 59	26. REGISTRAR'S SIGNATURE Road Smith, M.D.

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

219B

MAY 6 1959

14111213 110824H

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 *Lawrence M. Billo*

Licensed Embalmer No. *4375*
P. O. Address *St. Louis, Mo.*

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.