

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023202

STATE FILE NUMBER

FILED JUL 1 1959 Registration District No. Primary Registration District No. Registrar No. 5822

S. 300
v. 1-57

4

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

City Registrar 6/19/59
 Dr. J. Nelson
 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 b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS, MO.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 1438 HICKORY
3. NAME OF DECEASED (Type or print) First Middle Last Joe Miller			4. DATE OF DEATH Month / Day / Year 5- / 26 / 59
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 3-22-81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN MINEX		10b. KIND OF BUSINESS OR INDUSTRY COAL	9. AGE (In years last birthday) 78
11. BIRTHPLACE (City and state or country) KY.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME JOHN		13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE ADA MILLER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) ??		16. SOCIAL SECURITY NO. ??	17. INFORMANT Address ST. LOUIS CITY HOSP. #1.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral vascular accident			INTERVAL BETWEEN ONSET AND DEATH unk
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) 331 X			
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 type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 5-14-59 to 5-25-59 and last saw her alive on 5-25-59 Death occurred at 1:25 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Jean A. Chapman MD.		22b. ADDRESS 1515 Lafayette Ave.	22c. DATE SIGNED 5-26-59
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 6-19-59	23c. NAME OF CEMETERY OR CREMATORY HEERIN CITY	23d. LOCATION (City, town, or county) (State) HEERIN, ILL
24. FUNERAL DIRECTOR John Gonosk East St. Louis		25. DATE REGD. BY LOCAL REG. JUN 19 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

mrc

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.

Not Embalmed

Student
Signature of Student Embalmer

Signed *John A. Goussh*
Licensed Embalmer No. *3398*
P. O. Address

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.