URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-030647
STATE FILE NUMBER

FILED AUG 24 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 7421

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 4 days
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St. Louis-Little Rock Hosp, Inc.
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Illinois b. COUNTY
c. CITY OR TOWN: Granite City
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2813 Emzee
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Earl Middle: Thomas Last: Miller
4. DATE OF DEATH: Month: August Day: 8 Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 4-24-1888
9. AGE (last birthday): 71
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pensr. Crossing Watchman
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (City and state or country): Mindon, Nebraska
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: John Miller
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: ———
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 333-03-2716
17. INFORMANT: Dolly Wood Address: 2813 Emzee, Granite City, Ill

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myeloid Luekemia — INTERVAL BETWEEN ONSET AND DEATH: 1 year
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 204.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PEREORMED? 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 August 5, 1959 to August 8, 1959 and last saw him alive on August 8, 1959
Death occurred at 2:10 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Benjamin H. Clark, M.D.
22b. ADDRESS: 1755 S. Grand Blvd.
22c. DATE SIGNED: 8-9-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Aug. 12-1959
23c. NAME OF CEMETERY OR CREMATORY: Sunset Hill
23d. LOCATION (City, town, or county) (State): Edwardsville Illinois
24. FUNERAL DIRECTOR ADDRESS: Leonard Davis Funeral Home-Granite City, Ill
25. DATE REC'D BY LOCAL REG.: AUG 10 59
26. REGISTRAR'S SIGNATURE: Hearl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Leonard R. Davis

Licensed Embalmer No. 8375

P. O. Address Granite

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