

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-017147

FILED VS MAY 13 1960

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in lb <b>6mo. 20dys</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis Chronic Hosp</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4838 Ladue</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Blumia</b> Middle <b>Miller</b> Last			4. DATE OF DEATH Month <b>April</b> Day <b>28</b> , Year <b>1960</b>				
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10/15/1891</b>	9. AGE (last birthday) <b>68</b>	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) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Tenn. Hardman</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	

13a. FATHER'S NAME <b>Silas Rutledge</b>		13b. MOTHER'S MAIDEN NAME <b>Ceily Hartmanns</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Alma Travis</b> Address <b>---4825 Hammett Place</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 1/2 mo.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Term. Bronchopneumonia - 10 days.</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <b>443x</b>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		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 **Oct. 8, 1959** to **April 28, 1960** and last saw her/him alive on **April 28, 1960**  
Death occurred at **2:40 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>John W. Beckham, M.D.</b>		22b. ADDRESS <b>5800 Arsenal</b>		22c. DATE SIGNED <b>4/28/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5/2/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oakdale Cemete ry</b>		23d. LOCATION (City, town, or county) (State) <b>LeMay, Missouri</b>

24. FUNERAL DIRECTOR <b>E.B. Kense</b> ADDRESS <b>1221 North Grand</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 2 1960</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Flarence G. [Signature]

Licensed Embalmer No. 775  
P. O. Address 1221 [Signature]

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