

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040589

FILED VS NOV 9 1960 317

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3128

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Saint Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Bollinger		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Normandy		Length of stay in 1b 1 day	c. CITY OR TOWN Lutesville		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Normandy Osteopathic Hospital			Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle ROY Last Miller			4. DATE OF DEATH Month Oct. Day 25. Year 1960		
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 11-23-1897	9. AGE (last birthday) 62 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (City and state or country) Grassy, Mo.	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Miller, Samuel		13b. MOTHER'S MAIDEN NAME Boyett, Nona		14. NAME OF HUSBAND OR WIFE Pearl Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes World War I		16. SOCIAL SECURITY NO. 500-18-7956	17. INFORMANT Charles Kreeand-Rt. 4, Box 171 Address St. Charles, Missouri		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Paralysis DUE TO (b) Cerebral Embolism. DUE TO (c) Arterial fibrillation Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH Sec. min. days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cardiac decompensation - Generalized arteriosclerosis					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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.)			
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 10/25/60 to 10-25-60 and last saw him alive on 10-25-60 Death occurred at 9:25 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) William D. McIlwain J.D.			22b. ADDRESS 7011 Carondelet Clayton St.		22c. DATE SIGNED 10-27-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-28-60	23c. NAME OF CEMETERY OR CREMATORY MARION MEM. PK.	23d. LOCATION (City, town, or county) Advance, Mo.		(State)
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.			25. DATE RECD. BY LOCAL REG. 10-28-60	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 22 1960

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Elmo L. Radwin

Licensed Embalmer No. 4077

P. O. Address St Louis

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.