

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis MO		Length of stay in 1b	c. CITY OR TOWN St. Louis
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hosp		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7820 Neil
3. NAME OF DECEASED (Type or print) First Middle Last Donald Miller			4. DATE OF DEATH Month Day Year 1-28-1961
5. SEX M.	6. COLOR OR RACE W.	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-27-1961
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. 1 1 1 1
11. BIRTHPLACE (City and state or country) St. Louis MO		12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Clarence Miller		13b. MOTHER'S MAIDEN NAME Belores Lamma	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Clarence Miller 7820 Neil	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal Inanition			INTERVAL BETWEEN ONSET AND DEATH 60 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 773.0 DUE TO (c)			
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. <input type="checkbox"/> Yes <input 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.)	
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 1-27-61 to 1-28-61 and last saw her/him alive on 1-27-61. Death occurred at 8:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert A. Brennan M.D.		22b. ADDRESS 3606 Dravis	22c. DATE SIGNED 1-30-61
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 2-1-1961	23c. NAME OF CEMETERY OR CREMATORY Mt Olive Cem	23d. LOCATION (City, town, or county) (State) Lamar 25 MO
24. FUNERAL DIRECTOR Ambermille 3819 S. Grand St		25. DATE RECD. BY LOCAL REG. JAN 31 1961	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.

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 *Not Embalmed*
Geo. Hengeman
Licensed Embalmer No. _____

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.