

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2394**

FILED MAR 27 1961

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois COUNTY St. CLAIR		c. CITY OR TOWN East St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis - Little Rock Hospitals, Inc.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1325 North 11th. Str.,			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Helen Middle L. Last Miller				4. DATE OF DEATH Month March Day 10, Year 1961		5. SEX Female		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 7-9-1901	9. AGE (last birthday) 59	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) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (City and state or country) California, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.						
13a. FATHER'S NAME Not known			13b. MOTHER'S MAIDEN NAME Not known			14. NAME OF HUSBAND OR WIFE Paul Miller							
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. None		17. INFORMANT Paul W. Miller		Address 1325 N. 11th E. St. Louis Ill.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced Ca of Vagina DUE TO (b) Invasion of Bladder and Perineum DUE TO (c) Pronounced Anemia 176.1										INTERVAL BETWEEN ONSET AND DEATH			
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 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.)									
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 July 28, 1960 , to March 10, 1961 and last saw ^{her} _{him} alive on Mar. 10, 1961 Death occurred at 10:20 P. m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE Royal A. Weir, M.D. (Degree or title)					22b. ADDRESS 1755 So. Grand Ave.			22c. DATE SIGNED MAR 13 1961					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 3-13-61		23c. NAME OF CEMETERY OR CREMATORY Missouri Crematory		23d. LOCATION (City, town, or county) St. Louis, Missouri		(State)					
24. FUNERAL DIRECTOR Kassly Funeral Home			ADDRESS E. St. Louis, Ill.		25. DATE RECD. BY LOCAL REG. MAR 13 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 Max Embalmer, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed J. P. [Signature]

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.