

|   |                                      |  |   |  |   |
|---|--------------------------------------|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |                                      |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>ST. LOUIS</b>                                 |                                      | Length of stay in 1b<br><b>1 DAY</b>   | c. CITY OR TOWN <b>ST. LOUIS</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>ST. LUKES HOSPITAL</b>              |                                      | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><b>5323 DEVONSHIRE</b>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JENNIE</b> Middle <b>(N.M.I.)</b> Last <b>MILLER</b>                  |                                      |  | 4. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>25</b> Year <b>1961</b>   |  |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>CAUCASIAN</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8/16/1886</b>  | 9. AGE (last birthday)<br><b>74</b>                                | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>       |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>  | 11. BIRTHPLACE (City and state or country)<br><b>RUSHVILLE, ILLINOIS</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>   |
| 13a. FATHER'S NAME<br><b>JOSEPH WEIS</b>  |                                      | 13b. MOTHER'S MAIDEN NAME<br><b>LYDIA ALLEN</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><b>CHARLES A. MILLER (DECEASED)</b> |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b> |                                      | 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |   | 17. INFORMANT<br><b>JEANNETTE MILLER</b> Address <b>SEE #2</b>     |   |

|  |  |  |   |
|--|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><i>Paul Johnson<br/>Rep. for<br/>3/25/61</i> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b>  |
| IMMEDIATE CAUSE (a) <b>Uremia with Acidosis</b>  |  |  |   |
| DUE TO (b) <b>arterio capillary glomerulosclerosis</b>   |  |  |   |
| DUE TO (c) <b>Diabetes</b>   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>260x</b>         |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

|   |   |   |  |
|---|---|---|--|
| 19. WAS AUTOPSY PERFORMED?<br>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.)<br><b>260x</b> |  |
| 20c. TIME OF INJURY<br>Hour . . . . . a.m. . . . .<br>p.m. . . . .  |   | 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 <b>3/25/61</b> to <b>death</b> and last saw her alive on <b>3/25/61</b><br>Death occurred at <b>9:00 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>William Henry M.D.</b>   |   | 22b. ADDRESS<br><b>100 N Euclid St</b>  |  |
| 22c. DATE SIGNED<br><b>3/27/61</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>   | 23b. DATE<br><b>3/28/1961</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. HOPE CEMETERY</b>  | 23d. LOCATION (City, town, or county) (State)<br><b>BELLEVILLE, ILLINOIS</b> |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>HOFFMEISTER COLONIAL MORTUARY<br/>6464 CHIPPEWA STREET ST. LOUIS, MISSOURI</b>   |   | 25. DATE RECD. BY LOCAL REG.<br><b>MAR 27 1961</b>  | 26. REGISTRAR'S SIGNATURE<br><b>Loan Smith, M.D.</b>                         |

DATE AMENDED  
 INSIDE OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed *Lewis C. Hoffmann*

Licensed Embalmer No. 3841

P. O. Address 7814 S. Broad

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.