

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-027779

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 1852

FILED JUL 19 1961

1. PLACE OF DEATH a. COUNTY St Louis County		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY ST LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkwood Mo		Length of stay in 1b 6-Months	c. CITY OR TOWN Kirkwood Mo Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Agnes Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 10341 Manchester Rd Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Pauline Middle Miller Last Miller			4. DATE OF DEATH Month 7 Day 2 Year 61
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-31-1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 83 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) Renaix Belgium		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Vital DeBacker		13b. MOTHER'S MAIDEN NAME Hortense DeDonder	
14. NAME OF HUSBAND OR WIFE Willis E. (Deceased)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Florence Miller 3863 West Pine Blvd	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <u>Cerebral Hemorrhage</u>		
DUE TO (c) <u>Generalized arteriosclerosis</u>		
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 May 1961 to 7-2-61 and last saw her alive on 6-30-61
Death occurred at 1255 Dan on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>A. J. Valera M.D.</u>	22b. ADDRESS <u>8787 Big Bend</u>	22c. DATE SIGNED <u>7-2-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-5-1961	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
24. FUNERAL DIRECTOR <u>Arthur J. Donnelly</u>		23d. LOCATION (City, town, or county) (State) St Mary's Kansas

24. FUNERAL DIRECTOR <u>Arthur J. Donnelly</u>	ADDRESS <u>3840 Lindell Blvd</u>	25. DATE RECD. BY LOCAL REG. <u>7-3-61</u>	26. REGISTRAR'S SIGNATURE <u>J. C. Murphy M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

Dr Joseph C Vollmar

9756 Old Harrison Rd

No 1 - 3435

2 Block West of Rock Hill Rd.

Sunday - 1 P.M.

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,

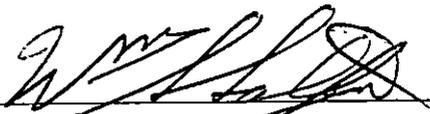
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed



Licensed Embalmer No. 4699

P. O. Address 3840 Lumbert

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.