

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-038970  
STATE FILE NUMBER

AMENDED

Registration District No. **318** Primary Registration District **1003** Registrar's No. **9740**

FILED NOV 8 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3300 Ohio</b>		d. STREET ADDRESS (If outside, give location) <b>3300 Ohio</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <b>Anna</b>	Middle <b>Bell</b>	Last <b>Miller</b>	4. DATE OF DEATH	Month <b>10</b>	Day <b>21</b>	Year <b>61</b>
-------------------------------------	-------------------	--------------------	--------------------	------------------	-----------------	---------------	----------------

5. SEX <b>F</b>	6. COLOR OR RACE <b>Cau</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1-8-1884</b>	9. AGE (last birthday) <b>77</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
-----------------	-----------------------------	--	----------------------------------	----------------------------------	---------------------------	------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cleaning Business</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Cleaners</b>	11. BIRTHPLACE (City and state or country) <b>Kentucky</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
---	--	---	--

13a. FATHER'S NAME <b>John Swaim</b>	13b. MOTHER'S MAIDEN NAME <b>Ella Hood</b>	14. NAME OF HUSBAND OR WIFE <b>Deventer</b>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	17. INFORMANT <b>St. Paul Minn.</b> <b>Loretta Miller 341 St. Peter</b>
---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>
DUE TO (b) <b>Generalized arteriosclerosis</b>		
DUE TO (c) <b>420.0</b>		

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 **1960** to **10/5/61** and last saw her alive on **10/5/61**  
Death occurred at **about 7:00/AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>N.P. Krawling MD</b>	(Degree or title)	22b. ADDRESS <b>3720 Washington Blvd St. Louis 8, Mo.</b>	22c. DATE SIGNED <b>10-21-61</b>
---	-------------------	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10-25-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Morley Cemetery</b>	23d. LOCATION (City, town, or county) <b>Morley, Mo.</b>	(State)
---	------------------------------	--	---	---------

24. FUNERAL DIRECTOR <b>McLaughlin Funeral Home</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>UCT 23 1961</b>	26. REGISTRAR'S SIGNATURE <b>Karl Smith, M.D.</b>
--	---------	--	--

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

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 H. Y. Farris

Licensed Embalmer No. 3384

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.

City and State

Signature of Embalmer

Date

Initials