

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

AMENDED

DATE AMENDED

INSTEAD OF

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

Registration District No. **318** Primary Registration District **1003** Registrar's No. **10684** STATE FILE NUMBER **61-042711**

**FILED NOV 28 1961**

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| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>ST. LOUIS, MO</b>                     |  | Length of stay in 1b   | c. CITY OR TOWN <b>ST. LOUIS</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>                                |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1</b> |  | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location) <b>2208 CARR</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print)<br>First <b>HUNTER</b> Middle Last <b>MILLER</b> | 4. DATE OF DEATH<br>Month <b>NOV.</b> Day <b>13,</b> Year <b>1961</b> |
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|                    |                               |   |                                   |                                  |   |                |
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| 5. SEX <b>MALE</b> | 6. COLOR OR RACE <b>NEGRO</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>7-14-1910</b> | 9. AGE (last birthday) <b>51</b> | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HR |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>----</b> | 11. BIRTHPLACE (City and state or country)<br><b>West Point, Miss.</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b> |
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| 13a. FATHER'S NAME<br><b>Unknown</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Unknown</b> | 14. NAME OF HUSBAND OR WIFE<br><b>LUELLA MILLER</b> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give year or dates of service)<br><b>YES U. W. #2</b> | 17. INFORMANT Address<br><b>Luella Miller 2208 Carr St.</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCT</b> | INTERVAL BETWEEN ONSET AND DEATH |
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| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>420.1</b> | DUE TO (c) |
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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>SUBARACNOID HEMORRAGE BRONCHOPNEUMONIA</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 |
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| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input 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.) |
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| 20c. TIME OF INJURY<br>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 |
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| 21. I attended the deceased from <b>11/6/61</b> to <b>11/13/61</b> and last saw her/him alive on <b>11/3/61</b><br>Death occurred at <b>12:35 P</b> on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <b>J. E. D... M.D.</b> (Degree or title) | 22b. ADDRESS <b>1515 LAFAYETTE AVE</b> | 22c. DATE SIGNED <b>11/13/61</b> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b> | 23b. DATE <b>11-20-61</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NATIONAL CEMETARY</b> | 23d. LOCATION (City, town, or county) (State)<br><b>JEFFERSON BARRACK, MO.</b> |
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| 24. FUNERAL DIRECTOR<br><b>McCLAIN</b> | ADDRESS<br><b>2812 CASS</b> | 25. DATE RECD. BY LOCAL REG.<br><b>NOV 17 1961</b> | 26. REGISTRAR'S SIGNATURE<br><b>Loed Smith M.D.</b> |
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| 27. MEDICAL CERTIFICATION |
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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Wallace R. Williams*

Licensed Embalmer No. 4926

5135 Latus  
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.