

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-008460

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2044

FILED FEB 23 1962

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
Rev. 4/59				
1				
2 <u>220</u>				
3				
4 <u>1</u>				
5 <u>2</u>				
6				
7 <u>1</u>				
8 <u>2</u>				
9				
10				
11				
12 <u>91-0</u>				
13				
91	SHOULD READ	BY AFFIDAVIT OF		

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3016a Kossuth</u>		d. STREET ADDRESS (If outside, give location) <u>3602 N. 23rd. St.</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary A. Miller</u>			4. DATE OF DEATH Month Day Year <u>2 18 62</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/27/1879</u>
9. AGE (last birthday) <u>82</u>	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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Indiana</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13a. FATHER'S NAME <u>Thomas Fowler</u>	
13b. MOTHER'S MAIDEN NAME <u>Margaret Seitz</u>		14. NAME OF HUSBAND OR WIFE <u>Wm. Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Miss M. Miller 3016 a Kossuth</u>
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>Acute Coronary Occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio-sclerosis</u>			
DUE TO (c) <u>4201</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Art. Sclerotic Heart Disease</u>			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 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 <u>January 1962</u> to <u>Feb. 1962</u> and last saw her <u>alive</u> on <u>2/16/62</u> Death occurred at <u>7:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>H. O. Mowrey M.D.</u>		22b. ADDRESS <u>231 Northland Medical Bldg</u>	22c. DATE SIGNED <u>2/19/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2/21/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Robert D. Kinealy 2228 St. Louis Ave.</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 19 1962</u>	26. REGISTRAR'S SIGNATURE <u>Coal Smith M.D.</u>

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 *Robert J. Ganje*
Licensed Embalmer No. 4800

P. O. Address Kirkwood 22 Mo.

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.