

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-020752
5551 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

DO NOT WRITE ON THIS STUB

AMENDED

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|---|----------------------------------|
| FILED JUN 7 1962 | |
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> Length of stay in 1b _____ | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4316 Laclede</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____ | |
| c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. STREET ADDRESS (If outside, give location) <u>4316 Laclede</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>B.</u> Last <u>Miller</u> | |
| 4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1962</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> |
| 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-8-1878</u> |
| 9. AGE (last birthday) <u>83</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 _____ | |
| 11. BIRTHPLACE (City and state or country) <u>Illinois</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>Frank King</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Mary Harrison</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Peter H. 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. _____ | |
| 17. INFORMANT <u>Roy Miller 4316 Laclede</u> Address _____ | |
| 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>Carcinoma of Urinary Bladder</u> DUE TO (b) <u>Carcinoma testis</u> DUE TO (c) <u>1810</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | |
| 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 <u>Feb. 1961</u> to <u>June 2, 1962</u> and last saw her <u>alive on June 1, 1962</u> . Death occurred at <u>June 2, 1962 - 2:50 am</u> on the date stated above, and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE <u>Rowan Malles M.D.</u> (Degree or title) | |
| 22b. ADDRESS <u>505 University Club Bldg.</u> | |
| 22c. DATE SIGNED <u>5/2/62</u> (State) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | |
| 23b. DATE <u>June 4, 1962</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla</u> | |
| 23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>A. J. Donnelly, 3840 Lindell</u> ADDRESS _____ | |
| 25. DATE RECD. BY LOCAL REG. <u>JUN 4 1962</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u> | |

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W. E. Salzen

Licensed Embalmer No. 4699

P. O. Address 3840 Lindell

- 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.