

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044633

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED **F**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11019**

STATE FILE NUMBER

**FILED NOV 26 1962**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

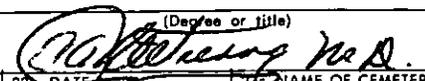
SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Reside on Farm		
		<b>St. Louis, Mo.</b>		<b>35 yrs.</b>		<b>Mo.</b>				<b>St. Louis</b>		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in Hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS		(If outside, give location)				<b>2003 Virginia</b>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
<b>St. Louis State Hosp.</b>														
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH		
			<b>ESTHER</b>			<b>(KLING)</b>			<b>MILLER</b>			<b>Nov. 15, 1962</b>		
5. SEX		6. COLOR OR RACE		7. MARRIAGE STATUS		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR		
<b>Female</b>		<b>White</b>		Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		<b>11/22/80</b>		<b>81</b>		Months		Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY								
<b>Domestic</b>				<b>St. Louis, Mo.</b>		<b>America</b>								
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE						
<b>Unknown Kling</b>				<b>Unknown Cologna</b>				<b>William Miller</b>						
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.				17. INFORMANT Address						
<b>no</b>				<b>None</b>				<b>Anna H. Weber 2003 Virginia</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a)												<b>2 days</b>		
DUE TO (b) <b>Emphysema</b>														
DUE TO (c) <b>Pneumonitis</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 <b>Oct. 3, 1927</b>		to <b>Nov. 15, 1962</b>		and last saw <sup>her</sup> alive on <b>Nov. 15, 1962</b>		Death occurred at <b>7:50 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title)				22b. ADDRESS				22c. DATE SIGNED						
				<b>5400 Arsenal St.</b>				<b>11-15-62</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)								
<b>Removal</b>		<b>11-17-1962</b>		<b>Zion Cemetery</b>		<b>St. Louis Co., Mo.</b>								
24. FUNERAL DIRECTOR ADDRESS				25. DATE RECD. BY LOCAL REG.				REGISTRAR'S SIGNATURE						
<b>Witt Mortuary 6409 Gravois</b>				<b>NOV 16 1962</b>				<b>Loan Smith, M.D.</b>						

MISSOURI

STATE OF MISSOURI

DEPARTMENT OF HEALTH

**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 Yan M. Sizemore

Licensed Embalmer No. 4343

P. O. Address St. Louis, 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.