

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-021973

DO NOT WRITE ON THIS STUD

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5381**

STATE FILE NUMBER

FILED JUN 13 1963

VS 300 Rev. 4/59	DATE AMENDED
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		a. STATE Missouri b. COUNTY St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Barnes Hospital		c. CITY OR TOWN Lemay	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 180 Kingston Drive	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GERALD IRA MILLER			4. DATE OF DEATH Month Day Year May 18 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/30/41
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician's Mate 3rd Cl.		9b. KIND OF BUSINESS OR INDUSTRY U. S. Coast Guard	9c. AGE (last birthday) 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician's Mate 3rd Cl.		10b. KIND OF BUSINESS OR INDUSTRY U. S. Coast Guard	11. BIRTHPLACE (City and state or country) Ashland, Nebraska
12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Donald I. Miller (Dec'd)		13b. MOTHER'S MAIDEN NAME Laura J. Jarman	
14. NAME OF HUSBAND OR WIFE Barbara Anne Rouf			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes 7-28-1959 to 5-18-1963		16. SOCIAL SECURITY NO.	
17. INFORMANT Barbara Anne Miller		Address 180 Kingston Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1 Left Hemothorax; 2 Laceration of Spleen; 3 Hemorrhage, suffered in auto accident in Jefferson, County, Missouri, May 18th, 1963. CAUSE AND MANNER OF SAME COULD NOT BE DETERMINED. DUE TO (b) Open Verdict DUE TO (c) Open Verdict			INTERVAL BETWEEN ONSET AND DEATH
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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT - SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) See Above	
20c. TIME OF INJURY: Hour Month, Day, Year ? a.m. 5-18-63			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway 48	20f. CITY, TOWN, OR LOCATION Jefferson County, Missouri	COUNTY STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 6:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Nelen L. Taylor Coroner		22b. ADDRESS 1300 Clark Ave.	22c. DATE SIGNED 5-20-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5/21/63	23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	23d. LOCATION (City, town, or county) (State) Ashland, Nebraska
24. FUNERAL DIRECTOR ADDRESS Beiderwieden F.H.Inc. 1936 St. Louis		25. DATE RECD. BY LOCAL REG. MAY 20 1963	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

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 _____

Licensed Embalmer No. 4520

P. O. Address St James, Md

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.