

THE DIVISION OF HEALTH OF MISSOURI,  
STANDARD CERTIFICATE OF DEATH

37301

State File No. \_\_\_\_\_

FILED NOV 12 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 2658

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Gravois</u> )		c. CITY (If outside corporate limits, write RURAL and give township) <u>2059</u> OR TOWN <u>St. Louis</u>	
c. LENGTH OF STAY (in this place) <u>10mos</u>		d. STREET ADDRESS (If rural, give location) <u>5837 Clemens</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Miller Nursing Home</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Clara</u>	b. (Middle) <u>Miller</u>	c. (Last) <u>Sherzer</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 13, 1952</u>
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 28, 1878</u>	9. AGE (In years last birthday) <u>74yrs</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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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>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>St. Louis Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Dr. John J. Miller</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Burd</u>	14. NAME OF HUSBAND OR WIFE <u>Dr. John J. Miller</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If you give war or dates of service) <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Edwin B. Sherzer</u>	ADDRESS <u>5837 Clemens Ave.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 Mo.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Heart and Kidney Disease</u>		
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____			442X
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis</u>			

19a. DATE OF OPERATION <u>no</u>	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR _____
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22. I hereby certify that I attended the deceased from Dec. 30, 1951 to Oct. 13, 1952, that I last saw the deceased alive on Oct. 11th 52 and that death occurred at 5:13<sup>5</sup> m., from the causes and on the date stated above.

23a. SIGNATURE <u>W. H. Walter M.D.</u> (De free or title)	23b. ADDRESS <u>3608 S. Grand Blvd.</u>	23c. DATE SIGNED <u>10/15/52</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Oct. 15, 1952</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>10/15/52</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Danke M.D.</u>	P.T. 25. FUNERAL DIRECTOR'S SIGNATURE <u>Alexander &amp; Sons</u>	ADDRESS <u>6175 Delmar</u>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

Dr. Walters  
1 P.M.  
508 N Grand  
3608 S Grand

**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 .....  
Student Embalmer

Signed Bert Hoffman

Licensed Embalmer No. 4366

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 this body is not embalmed, fact should be so stated above.