

FILED NOV 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 37858
10644

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

S. 300
1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY								
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			c. CITY OR TOWN St. Louis			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1626 Semple			Length of stay in 1b			STREET ADDRESS 1626 Semple			(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Albert Miller						4. DATE OF DEATH Month Day Year Nov. 7, 1957					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1868		9. AGE (In years last birthday) 89		IF UNDER 1 YEAR Months Days Hours Min. 4 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer				10b. KIND OF BUSINESS OR INDUSTRY City Of St. Louis		11. BIRTHPLACE (City and state or country) St. Louis		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME David Miller				13b. MOTHER'S MAIDEN NAME Mary				14. NAME OF HUSBAND OR WIFE Nellie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 490-12-8490		17. INFORMANT Address Archibald Kaatman 1626 Semple					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ang. Spel. Heart Disease</i> <i>Chg. Bacteremia</i> DUE TO (b) <i>Bacteremia</i> DUE TO (c) <i>Bacteremia of St. Leg</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <i>Shrubby</i> 420.0										INTERVAL BETWEEN ONSET AND DEATH	
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 a.m. p.m.											
20d. INJURY OCCURRED WHILE AT <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 <i>8/10/57</i> to <i>11/7/57</i> and last saw him alive on <i>10/28/57</i> Death occurred at <i>10:20</i> A m on the date stated above; and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <i>Robert G. Farrell M.D.</i>						22b. ADDRESS <i>624 N. Union</i>			22c. DATE SIGNED <i>11/8/57</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE <i>11/9/57</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>			23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>				
24. FUNERAL DIRECTOR Chas. F. Stuart				ADDRESS <i>1225 Union</i>		25. DATE RECD. BY LOCAL REG. <i>NOV 8 57</i>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i> <i>S.P.</i>			

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 M. Murray*

Licensed Embalmer No. *37490*
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.