Health, & Welfare Public Service

S. 300
1-57

FILED FEB 28 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-007581
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1437

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MISSOURI — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION: 04 BARNES HOSPITAL — Length of stay in 1b: 6 weeks

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Illinois
b. COUNTY:
c. CITY OR TOWN: Centralia — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS: 32 (If outside, give location) — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: IVAH Middle: ZOE Last: MILLER

4. DATE OF DEATH Month Day Year: FEBRUARY 4, 1958

5. SEX: F.
6. COLOR OR RACE: W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 15, 1902
9. AGE (In years last birthday): 55 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Illinois
12. CITIZEN OF WHAT COUNTRY?: U. S.

13a. FATHER'S NAME: Henry McLain
13b. MOTHER'S MAIDEN NAME: unknown
14. NAME OF HUSBAND OR WIFE: C. C. Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: C. C. Miller Address: Centralia, Ill.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

MEDICAL CERTIFICATION

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)	HEPATORENAL SYNDROME	12 HOURS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	BILIARY CIRRHOSIS, SEVERE	1 YEAR
DUE TO (c)	581.0	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 DEC. 14, 1957, to FEB. 4, 1958 and last saw her/him alive on FEB. 4, 1958
Death occurred at 5:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: C. R. Vermillion, M.D. (Degree or title) M. D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 2/5/58

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: Feb. 5, 1958
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City, town, or county) (State): Centralia, Illinois

24. FUNERAL DIRECTOR: Queen-Boggs ADDRESS: Centralia, Ill.
25. DATE RECD. BY LOCAL REG.: FEB 7 '58
26. REGISTRAR'S SIGNATURE: J. Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

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 Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address Florissant, S

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.