

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-049066

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 3724

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 10 1963

1. PLACE OF DEATH a. COUNTY: <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: <u>Rock Hill</u> Length of stay in 1b: <u>Month</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: <u>Missouri</u> b. COUNTY: <u>St. Charles</u> c. CITY OR TOWN: <u>St. Charles</u> Inside Limits: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location): <u>822 Monroe</u> Residence on Farm: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: <u>Rock Hill Rest Home</u> Inside Limits: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location): <u>822 Monroe</u> Residence on Farm: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First: <u>Ada</u> Middle: <u>L.</u> Last: <u>Miller</u>			4. DATE OF DEATH Month: <u>December</u> Day: <u>18</u> Year: <u>1962</u>			
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/23/82</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months: _____ Days: _____	IF UNDER 24 HR Hours: _____ Min.: _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Worker</u>	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and state or country) <u>St. Charles, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Aloys M. Miller</u>	13b. MOTHER'S MAIDEN NAME <u>Betty Behrens</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Maud Edwards, St. Charles, Mo.</u> Address: <u>822 Monroe</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>50 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____ DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fractures of both legs</u>	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
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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.) <u>FELL DOWN STEPS AT HOME</u>
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20c. TIME OF INJURY Hour: _____ a.m. _____ p.m.	Month, Day, Year: _____
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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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from Nov. 21, 1962 to Dec. 18, 1962 and last saw her ^{her} ~~him~~ alive on Dec. 18, 1962
 Death occurred at 4 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Arthur C. Baue, MD</u>	22b. ADDRESS <u>1502 Cass St</u>	22c. DATE SIGNED <u>12-20-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>12/21/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Charles, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Arthur C. Baue-St. Charles, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-20-62</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy, M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

VS 300 Rev. 4/59
 14038
 209222
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STATE OF MISSISSIPPI

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 Connie L. Pickering

Licensed Embalmer No. _____

P. O. Address _____

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.