

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-017970

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3950**

STATE FILE NUMBER

FILED APR 17 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59	1	28/20-71	3	4 0	5 1	6	7 1	8 1	9	10	11	12 52-3	13
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF													
DATE AMENDED													
MEDICAL CERTIFICATION													
BY AFFIDAVIT OF													
DOCUMENT													
USE BLACK INK OR TYPEWRITER RIBBON													
SHOULD READ													
ITEM NO.													

<b>1. PLACE OF DEATH</b> a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b> Length of stay in lb c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Barnes Hospital</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> . b. COUNTY <b>Calhoun</b> c. CITY OR TOWN <b>Hardin</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Lyman</b> Middle <b>Decalb</b> Last <b>Miller</b>			<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>7</b> Year <b>1963</b>				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>8/23/1907</b>	<b>9. AGE</b> (last birthday) <b>55</b>	IF UNDER 1 YEAR Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Operator Engineer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Quarry Co.</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Well County, Arkansas</b>			
<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>			<b>13a. FATHER'S NAME</b> <b>John Miller</b>				
<b>13b. MOTHER'S MAIDEN NAME</b> <b>Arminda Lane</b>			<b>14. NAME OF HUSBAND OR WIFE</b> <b>Florence</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) No. Nil.		<b>16. SOCIAL SECURITY NO.</b> [Redacted]		<b>17. INFORMANT</b> Address <b>Florence Miller, Hardin, Illinois.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured Aortic Aneurysm</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>4.51x</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)				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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____							
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE			
<b>21. I attended the deceased from _____ to _____ and last saw her/him alive on _____.</b> Death occurred at <b>10:30 p</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <b>Walter L. Taylor, Coroner</b>				<b>22b. ADDRESS</b> <b>1300 Clark Ave.</b>			
<b>22c. DATE SIGNED</b> <b>4-8-63</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>		<b>23b. DATE</b> <b>4-10-63</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Irving Cemetery</b>			
<b>23d. LOCATION</b> (City, town, or county) <b>Irving, Illinois.</b>							
<b>24. FUNERAL DIRECTOR</b> <b>Hanks Funeral Home, Hardin, Illinois.</b>			<b>25. DATE RECD. BY LOCAL REG.</b> <b>APR 8 1963</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Earl Smith, M.D.</b>		

**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 E. J. Remelius

Licensed Embalmer No. 4283  
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.