

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-021978

STATE FILE NUMBER

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

5052

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|---|---|--|
| 1. PLACED FILED MAY 17 1963 | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY | | a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 11 days | c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 8527 Lowell Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) JULIUS E (MUELLER) MILLER | | | 4. DATE OF DEATH Month May Day 8 Year 1963 |
| 5. SEX male | 6. COLOR OR RACE white | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 8/6/1888 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterworks employee | | 10b. KIND OF BUSINESS OR INDUSTRY City Government | 11. BIRTHPLACE (City and state or country) St. Louis, Missouri |
| 12. CITIZEN OF WHAT COUNTRY U. S. A. | | 13. FATHER'S NAME Charles Miller | |
| 14. MOTHER'S MAIDEN NAME Albertine Schultz | | 14. NAME OF HUSBAND OR WIFE Agnes Miller | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of) | | 16. SOCIAL SECURITY NO. | |
| No | | Agnes Miller - 8527 Lowell | |
| 18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cerebral thrombosis | | | 12 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | |
| DUE TO (b) Cerebral arteriosclerosis | | | |
| DUE TO (c) 332 | | | |
| 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. |
| Alimenty - myocardial failure - ASHD - NCD. | | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 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.) | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | Month, Day, Year | | |
| 20d. INJURY OCCURRED WHILE AT WORK <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 4/27/63 to 6/7/63 and last saw him alive on 6/7/63 Death occurred at 6:10 AM on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Franklin P. Hays | | 22b. ADDRESS 10011 Bellefontaine Rd | 22c. DATE SIGNED (Sign) 5/9/63 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | 23b. DATE May 10, 1963 | 23c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery | 23d. LOCATION (City, town, or county) St. Louis County Missouri |
| 24. FUNERAL DIRECTOR ADDRESS BUCHHOLZ MORTUARY-5967 W. Florissant Ave | | 25. DATE RECD. BY LOCAL REG. MAY 10 1963 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. |

USE BLACK INK OR TYPEWRITER RIBBON

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2089

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 *Richard E. Buckhoff*

Licensed Embalmer No. 4551

P. O. Address *St. Louis*

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.