

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-050313

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 546 Registrar's No. 3545

FILED DEC 20 1963

VS 300  
Rev. 4/59  
1 400X  
2 207  
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88

DATE AMENDED  
INSTEAD OF  
SHOULD READ  
ITEM NO.

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis-Overland Missouri</b>		Length of stay in 1b <b>5 weeks</b>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Good Shepherd Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5507 Beacon Avenue</b>
3. NAME OF DECEASED (Type or print) First <b>Hilda</b> Middle <b>M.</b> Last <b>Miller</b>		4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>1963</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-18-1889</b>
9. AGE (last birthday) <b>73 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired President</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mo. Brass Type Boun.</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Fahrenkrog</b>	
13b. MOTHER'S MAIDEN NAME <b>Johanna</b>		14. NAME OF HUSBAND OR WIFE <b>deceased</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		17. INFORMANT <b>Mr. Ralph Harbo</b> <b>9256 E. Breckenridge St. Louis 14</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction of Target</b>		INTERVAL BETWEEN ONSET AND DEATH <b>141.9</b>	
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)	
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		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 <b>10-63</b> to <b>present</b> and last saw her alive on <b>11-16-63</b> Death occurred at <b>5:23</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>Marion R. ...</b>	
22b. ADDRESS		22c. DATE SIGNED <b>11-18-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-20-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Friedens Cemetery</b>
23d. LOCATION (City, town, or county) <b>St. Louis County, Missouri</b>		24. FUNERAL DIRECTOR ADDRESS <b>Math Hermann &amp; Son, Inc. 2161 East Fair St. Louis, Missouri 62107</b>	
25. DATE RECD. BY LOCAL REG. <b>11-19-63</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF MISSISSIPPI

DEPARTMENT OF HEALTH

**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

*Julius R. Brown*

Licensed Embalmer No. 5146

P. O. Address Shreveport, 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.