N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

17083

791

1003

File No.

Registered No. 5050

1. PLACE OF DEATH

County

Registration District No.

Township

Primary Registration District No.

City St. Louis (No. City Hospital #1 St. Ward)

2. FULL NAME Ralph H. Miles

(a) Residence. No. American Annex Hotel St., 25 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Unknown

7. AGE: Alt — YEARS: 36 — MONTHS: ✓ — DAYS: — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Cashier
(b) General nature of industry, business, or establishment in which employed (or employer): Madison Kennel Club
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Indiana

PARENTS

10. NAME OF FATHER: Franklin Miles

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ind.

12. MAIDEN NAME OF MOTHER: Ada Hall

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ind.

14. INFORMANT: H. W. Fath
(Address) Coroner's Office

15. FILED MAY 30 1927 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1

16. DATE OF DEATH (MONTH, DAY AND YEAR): 5/29 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 8-45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Gunshot Wound of Abdomen
173
Homicide
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): 197
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) H. W. Fath M.D.

5/30, 1927 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Little Rivers Fla.

DATE OF BURIAL: 6/2 1927

20. UNDERTAKER: Southern

ADDRESS: 7315 S. Bdway