

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

Do not use this space.

23065

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **2852**) **Shenandoah** St. _____ Ward _____

File No.
 Registered No. **6752**

2. FULL NAME

Earl Miller

(a) Residence. No. **2852 Shenandoah** **13** 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) **Divorced**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Ethel Miller**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Aug 4th 1901**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	25	11	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Chauffeur**
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **Ill.**

10. NAME OF FATHER

Daniel Miller

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **Ill.**

12. MAIDEN NAME OF MOTHER

Mellie Johnson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **Ill.**

14.

INFORMANT (Address) **Mrs. Mary Van Gandt Centralia Ill.**

15.

FILED **26 1927** **Max B. Starceff** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **7-24 1927**

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at **9:52 P.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1630
Carbolic Acid Poisoning

Suicide (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

166 (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.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) **A. D. Dath** M.D.

7/26, 19 (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

DATE OF BURIAL

Murphyboro Ill **7-27 1927**
20. UNDERTAKER ADDRESS

Arthur J. Donnelly 2039 West St

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.

STATEMENT RECORD

