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

Do not use this space.

38354

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 11019

City St. Louis, Missouri (No. City Infirmary St. ..... Ward)

2. FULL NAME John Miller

(a) Residence. No. 5800 arsenal St., or 13 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: m
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 29, 1852.

7. AGE: Years 75 | Months 1 | Days 7. | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Cabinet maker.
(b) General nature of industry, business, or establishment in which employed (or employer): Odd jobs.
(c) Name of employer

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

PARENTS
10. NAME OF FATHER: George B. Miller
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: Margaret Dierges
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

14. INFORMANT ~~[illegible]~~
(Address) Marie Effinger

15. FILED DEC -9 1927 19 5800 Arsenal St Max C. Starkloff REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12 - 6 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1927, to Dec 6, 1927 that I last saw him alive on 12 - 6, 1927 and that death occurred, on the date stated above, at 11 30 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
90 Bilbao
(duration) Many yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Senility
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Chas W. Sechrist, M. D
, 19 (Address) 5800 arsenal

*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: Calvary Cemetery | DATE OF BURIAL: Dec. 10 1927

20. UNDERTAKER: J. H. Gibken | ADDRESS: 2842 Miramar

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.