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

Do not use this space.

39100

1. PLACE OF DEATH

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

Township St. Louis Primary Registration District No. 1003 Registered No. 159

City St. Louis (No. 5384 Wells Ave. St. ..... Ward)

2. FULL NAME Carrie Miller

(a) Residence. No. 5384 Wells Ave St., 7 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 Female

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) Unknown

7. AGE Abt

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
65	✓	✓	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(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) Missouri

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER ✓ ✓

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

14. INFORMANT Coroner Office
(Address) Jos. Kerner

15. FILED JAN -5 1928, 19..... Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Found dead Dec. 25 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 10 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) W. M. A.

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 908

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

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. S. Vitt, M. D

1/4, 1928 (Address) Coroner CC

*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 Valhalla

DATE OF BURIAL 1/5/28 19..

20. UNDERTAKER Southern

ADDRESS 7315 S Bdwy

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.