WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

26383

1. PLACE OF DEATH

County ..... Registration District No. 791 1003

Township ..... Primary Registration District No. .....

City St. Louis Mo. (No. St. Johns Hosp. St. ..... Ward)

File No. .....

Registered No. 7609

2. FULL NAME George P. Miles

(a) Residence. No. 4557 Chouteau St., 18 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 6 - 1866

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	63	6	15	

8. OCCUPATION OF DECEASED

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

(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) St. Louis, Mo.

PARENTS

10. NAME OF FATHER Michael Miles

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT E. C. Miles
(Address) 4557 Chouteau

15. FILED JUL 23 1929, 19 Max C Starkloff REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 21 1929

17. I HEREBY CERTIFY, That I attended deceased from July 19, 1929, to July 21, 1929 that I last saw him alive on July 21, 1929, and that death occurred, on the date stated above, at 1:45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Peritonitis following Ruptured appendix

12 A

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

CONTRIBUTORY (SECONDARY) 117A

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

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 7-19-29

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Robt Hyland, M. D.

July 22, 1929 (Address) 3901 Park Ave

*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
Calvary Cem.	Jul. 24 1929

20. UNDERTAKER Sharby Funeral Ser. Co. 4365 Washington ADDRESS