

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

Do not use this space.

12598

1. PLACE OF DEATH
 County Jackson Registration District No. 208
 Township Howe Primary Registration District No. 3
 City St. Louis No. 2712 Broadway St. 4 Ward 4
 2. FULL NAME Dr. Benjamin M. Miller
 (a) Residence No. 2712 Broadway Ward 4
 (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.

File No. _____
 Registered No. 1524
 St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Ora M. Miller
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 2 - 1850
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
79 5 5
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Physician
 (b) General nature of industry, business, or establishment in which employed (or employer) Physician
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind
 10. NAME OF FATHER No Record
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) No record
 12. MAIDEN NAME OF MOTHER no record
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) no record

14. INFORMANT Ora M. Miller
 (Address) 2712 Broadway Ave.
 15. FILED 47, 19 30 M. M. Brown REGISTRAR
Asst

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr - 7 - 1930
 17. I HEREBY CERTIFY, That I attended deceased from 4 - 4, 1930, to 4 - 7, 1930
 that I last saw him alive on 4 - 6, 1930, and that death occurred, on the date stated above, at 10:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Coronary Atherosclerosis
59
131
9 1/2 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Diabetes and chronic arteriosclerosis
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS Urinal
 (Signed) W. A. Aronson, M. D.
4/7, 19 30 (Address) 650 Argyle Pl
 *State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15. PLACE OF BURIAL, CREMATION, OR REMOVAL Memorial Pk DATE OF BURIAL April 8 1930
 20. UNDERTAKER Mrs. C. L. Forster ADDRESS K.C. Mo.

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.

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Mr. M F Kelley
630 Orange Bldg. Vi 1293
3433 Pasco Li 7310

Grandview, Mo.

Hic. 8.