

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

Do not use this space.

210591-08  
File No. \_\_\_\_\_  
Registered No. **5896**  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**1. PLACE OF DEATH**

County \_\_\_\_\_  
Township \_\_\_\_\_  
City **St. Louis, Mo.**

Registration District No. **791**  
Primary Registration District No. **1003**  
City Hospital # **2**

**2. FULL NAME**

**Emma Lyle Miller**  
(a) Residence No. **2131 Chestnut** St., **21** Ward.

Length of residence in city or town where death occurred **10** yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <b>Female</b>	4. COLOR OR RACE <b>col.</b>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <b>Wid</b>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <b>unknown</b>		
7. AGE <b>abt 57</b>	YEARS	MONTHS
		DAYS
		If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <b>House-work</b> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		

9. BIRTHPLACE (CITY OR TOWN) **Miss.**  
(STATE OR COUNTRY)

10. NAME OF FATHER **Henry Miller**

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

12. MAIDEN NAME OF MOTHER **Rachael**

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

14. INFORMANT **A. Stroud**  
(Address) **City Hospital # 2**

15. FILED **18 1930**  
REGISTRAR **Mar C. Standley**

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **6-16-1930**

17. I HEREBY CERTIFY, That I attended deceased from **5-13-1930** to **6-16-1930** that I last saw her alive on **6-16-1930**, and that death occurred, on the date stated above, at **7:15 AM**.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Chronic Myocarditis**  
**93c**  
(duration) **1** yrs. — mos. — ds.  
CONTRIBUTORY (SECONDARY) **None**  
(duration) \_\_\_\_\_ yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? **NO**. DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? **NO**

WHAT TEST CONFIRMED DIAGNOSIS? **clinical**  
**A. E. Hale**, M. D.

(Signature) \_\_\_\_\_  
**6/16/1930** (Address) **City Hospital # 2**

\*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 **Okabona Muse**  
DATE OF BURIAL **6-19-1930**

20. UNDERTAKER **W. S. ...**  
ADDRESS **4202**

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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