

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

Do not use this space.

20046

1. PLACE OF DEATH

County Registration District No. **791.**
Township Primary Registration District No. **1008**
City **St. Louis** **ISOLATION HOSPITAL**

File No.
Registered No. **6078**
St. Ward)

2. FULL NAME

Mrs Delia Miller
(a) Residence. No. **4003 South Broadway** Ward **15**
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred **20** yrs. **7** mos. **7** 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) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frank Miller
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 18 1881
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
abt. 50 Unknown
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) Arkansas
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Leana Burns
(Address) ISOLATION HOSPITAL

15. FILED 24 May 1931
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-29 1931
17. I HEREBY CERTIFY, That I attended deceased from 5-16-31 19... to 5-29 1931
that I last saw her alive on 5-29 1931, and that death occurred, on the date stated above, at 5:05 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Erysipelas - Both Legs
15B Cause unknown
15B (duration) yrs. 1 mos. ds.
CONTRIBUTORY Pneumonia
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH...
19. DID AN OPERATION PRECEDE DEATH? no
20. WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) **P. F. Tompase**, M. D.
ISOLATION HOSPITAL

*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 New St Marcus.
DATE OF BURIAL May 31 1931

20. UNDERTAKER **ADDRESS** 1417 N. Market.
Leidner and Co.

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.

