

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

Do not use this space.

24152

1. PLACE OF DEATH

County Registration District No. *578*
 Township Primary Registration District No. *1*
 City *St. Louis* (No. *City Hospital #1*) St. Ward)

File No.
 Registered No. **6240**

2. FULL NAME

(a) Residence, No. *3512 N Grand* St., *10* 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 <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Divorced</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Lulu Miller</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>June 10 - 1885</i>		
7. AGE YEARS <i>47</i>	MONTHS <i>0</i>	DAYS <i>24</i>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Paper Hanger</i>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>?</i>		
10. Date deceased last worked at this occupation (month and year).....		11. Total time (years) spent in this occupation.....
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis Missouri</i>		
13. NAME <i>Frank Miller</i>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis Missouri</i>		
15. MAIDEN NAME <i>Annie Schneider</i>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis Missouri</i>		
17. INFORMANT (ADDRESS) <i>Auntie Miller 2209 Robert St</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Calvary Cemety</i> DATE <i>July 7</i> 193 <i>2</i>		
19. UNDERTAKER (ADDRESS) <i>Arthur J. Donnelly Undertaker 3844 Lindell Blvd</i>		
20. FILED <i>7-6-32</i> Registrar. <i>7/6/32</i>		

MEDICAL CERTIFICATE OF DEATH

1
 21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 4* 193*2*
 22. I HEREBY CERTIFY, That I attended deceased from *Dr. Phyllis St. Louis* 19... to 19...
 I last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, *11:35 a.m.*
 The principal cause of death and related causes of importance were as follows:
 Date of onset
Cerebral Apoplexy
J. A. [Signature]
 Other contributory causes of importance:
 Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? *Yes*
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? *✓* Date of injury..... 19...
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury *No injury*
 Nature of injury.....
 24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify.....
 (Signed) *J. A. [Signature]* M.D.
 (Address) *St. Louis*

WRITE CLEARLY, 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.

