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.

REC'D MAR 13 1939

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

4374
Do not use this space.

791

1. PLACE OF DEATH
(a) County
(b) Township
(c) City St. Louis
Registration District No. 1003
Primary Registration District No.
Registered No. 1067
(d) Street No. Jewish Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 30 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

460

2. PRINT FULL NAME Cora V. Miller,
(a) Residence, No. 1005 Hi-Point St. 4
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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: John M. Miller

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Aug. 28, 1883

7. AGE: YEARS 55 | MONTHS 5 | DAYS 3 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: At home
9. Industry or business in which work was done, as saw mill, bank, etc.
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): Frederick, Maryland.

FATHER
13. NAME: James A. Dronenberg
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Maryland.

MOTHER
15. MAIDEN NAME: Laura Clemm,
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Maryland.

17. INFORMANT (ADDRESS): John M. Miller, 1005 Hi-Point.

18. ~~BURIAL, CREMATION, OR REMOVAL~~
PLACE Valhalla Crem. DATE Feb 2, 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Wagoner Und. Co. 3621 Olive St.

20. FILED FEB 2 1939 J. F. Bredick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Feb. 1, 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov. 1932, to Feb. 1, 1939
I last saw her alive on Feb. 1, 1939 Death is said to have occurred on the date stated above, at 10:10 A.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Subacute bacterial endocarditis	6 mo
Other contributory causes of importance:	
Rheumatic heart dis.	Many
Mitral stenosis	Years

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 .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Llewellyn Sale, M. D.
(Address) 4500 Olive

(Licensed Embalmer's Statement on Reverse Side)

Mr. Sale

4500 Olive St

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed Neville B Frohwitter

Licensed Embalmer No. 3696

P. O. Address 3621 Olive St.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.