

AY 11 1939

REC'D JUN 8 1939

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

19831
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784
(b) Township _____ Primary Registration District No. 117
(c) City Webster Groves (d) Street No. _____ 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 2 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 867

2. PRINT FULL NAME

Edgar S. Miller
(a) Residence, No. 940 Providence Rd St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|----------------------------------|---|
| 3. SEX <u>Male</u> | 4. COLOR OR RACE <u>White</u> | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Gertrude</u> | | |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>9-8-69</u> | | |
| 7. AGE YEARS <u>69</u> | MONTHS <u>8</u> | DAYS <u>3</u> |
| If LESS than 1 day, _____ hrs. or _____ min. | | |
| 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Lumber & Tobacco</u> | | |
| 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) <u>1939 - Sept</u> | | 11. Total time (years) spent in this occupation |
| 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Springfield, Ohio</u> | | |
| 13. NAME <u>Jasper Miller</u> | | |
| 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u> | | |
| 15. MAIDEN NAME <u>Margaret Hubin</u> | | |
| 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u> | | |
| 17. INFORMANT (ADDRESS) <u>Leonard D. Gray 940 Providence Web Groves</u> | | |
| 18. BURIAL, CREMATION, OR REMOVAL PLACE <u>MOUND S Hill</u> DATE <u>May 14th 1939</u> | | |
| 19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Beiderwiedin Fun Home 1926 St. Louis Ave</u> | | |
| 20. FILED <u>MAY 11 1939</u> <u>Chas. R. Meyer</u> Local Registrar | | |

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-11 1939

22. I HEREBY CERTIFY, That I attended deceased from about May 1937, to May 11 1939
I last saw him alive on from May 30 1939. Death is said to have occurred on the date stated above, at 9 A. M.
The principal cause of death and related causes of importance were as follows:
Carcinoma of Colon ✓ Date of onset
Appendicitis
Chronic Myocarditis

Other contributory causes of importance:
Indigestion, Prailitis, Old Undersea High

Name of operation Removal of Prostate Date of 1939
What test confirmed diagnosis? _____ Was there an autopsy? no

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
(Signed) W. S. Paul M. D.
(Address) 5914 Belmont

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.

46

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.....

Licensed Embalmer No. 3737

P. O. Address 1936 St. Louis Ave

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

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

19831
Do not use this space.

1. PLACE OF DEATH *St. Louis*

(a) County *St. Louis* Registration District No. *784*

(b) Township *Webster Grove* Primary Registration District No. *117* Registered No. *869*

(c) City *Webster Grove* (d) Street No. _____ 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Edgar S. Miller*

(a) Residence, No. _____ St. (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 *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *M*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
69 8 3

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____

9. Industry or business in which work was done, as saw mill, bank, etc. _____ *46*

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) _____

FATHER

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL *1*
PLACE _____ DATE _____, 19____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____, 19____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *5-11-1979*

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____, in _____.

The principal cause of death and related causes of importance were as follows:
*Carcinoma of Colon
St. Proximal
Artericular fibrillation
Chronic myo Carditis*

Other contributory causes of importance:
*Hypertrophied Prostate
Ch. Intestinal neoplasia*

Name of operation *Removal prostate* Date of *1979-*

What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____
If so, specify _____
(Signed) *Neal J. Arnold*, M. D.
(Address) *3914 Delmar*

Local Registrar.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. No fee for information should be carefully supplied. AGE should be properly classified. Exact CAUSE OF DEATH in plain terms, that it may be properly classified. Exact

RECEIVED

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

19831

Do not use this space.

1. PLACE OF DEATH *St Louis*

(a) County *St Louis* Registration District No. *784*

(b) Township *Webster Groves* Primary Registration District No. *117*

(c) City *Webster Groves* (d) Street No. _____ (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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Edgar S. Miller*

(a) Residence, No. _____ St. _____ (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *m* 4. COLOR OR RACE *w* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *m*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *69 8 3*

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____

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) *Hyperthyroidism*

13. NAME *Section made for*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis*

15. MAIDEN NAME *Change of name*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis*

17. INFORMANT (ADDRESS) *most at all*

18. BURIAL, CREMATION, OR REMOVAL PLACE *NB: kept in home*

19. FUNERAL DIRECTOR (ADDRESS) *operation for*

20. FILED *1983* Local Registrar *only*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *3-11*, 19*83*

22. I HEREBY CERTIFY, That I attended deceased _____ to _____

I last saw him _____ alive on _____, 19____. Death is _____ to have occurred on the date stated above, at _____.

The principal cause of death and related causes of importance were as follows:

Cardiomyopathy, Myocardial infarction, Coronary atherosclerosis

Other contributory causes of importance: *Hypertrophic Prostate, Chronic Interstitial Nephritis*

Name of operation *Removal Prostate* Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____

If so, specify _____ (Signed) *Neal J. Grohler*, M. D.

(Address) *3914 Delmar*

MARGIN RESERVE FOR B.I.
 N. B.—E-41
 VITAL PLATE PL-41 shot WITH UNFADING INK—THIS he stated EXACTLY. PHYSICIANS should state EXACTLY. OCCUPATION is very important. SEVERAL items 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Nov 26 1893

The malignancy of Colon was discovered after the first operation. The patient would not submit to further surgery, even when obstructive symptoms were manifest.

We did not have any sections of tissues of Colon - but Dr. Ross - by Dr Ernst were strongly indicative of CA & the subsequent clinical course made such a diagnosis obvious.

W.F.

W.F.