

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.

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

21180  
Do not use this space.

## 1. PLACE OF DEATH

(a) County Jackson Registration District No. 5  
(b) Township New Primary Registration District No. 100 Registered No. 2448  
(c) City St. Louis, Mo. (d) Street No. 17 E. Sun Street 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

(a) Residence, No. 460 Joseph Miller (Joseph Miller)  
1415 Broadway 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Divorced  
(Write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec - 4 - 1874

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
64 6 9

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, none  
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) N. Y.

FATHER 13. NAME Sam Miller  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Paula Ottenheim  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N. Jersey

17. INFIRMANT (ADDRESS) 17 E. Sun Street

18. BURIAL, CREMATION, OR REMOVAL PLACE Green Lawn DATE June 16, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) John W. Wagner  
Kansas City, Mo.

20. FILED June 15 1939 M. M. Crow, ass't  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-13-39

22. I HEREBY CERTIFY, That I attended deceased from 6-8-39 1939, to 6-13-39 1939.  
I last saw him alive on 6-13-39 1939. Death is said to have occurred on the date stated above, at 5:35 am.

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

Carcinoma of  
Stomach - not un-  
formed 46  
Other contributory causes of importance:

Name of operation..... Date of.....

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?..... 1

If so, specify.....

(Signed) P. De Maria M. D.

(Address) 17 E. Sun Street

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**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.....

P. O. Address.....

**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.**