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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23629

DEC 8 AUG 11 1939 791

Registration District No. 1008 Primary Registration District No. Registrar's No. 5902

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3641 Cass Ave (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 1 yr years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St Louis (If outside city or town limits, write "RURAL") 11

(d) Street No. 3641 Cass Ave. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Alfred Miller 460

3. (b) If veteran, name war No

3. (c) Social Security No. —

4. Sex Male.

5. Color or race White.

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Julia Miller.

6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased 4 (Month) 12 (Day) 1853 (Year)

8. AGE: Years 86 Months 2 Days 19 If less than one day hr. min.

9. Birthplace (City, town, or county) Ohio (State or foreign country) 1

10. Usual occupation Laborer. 7

11. Industry or business 9

FATHER
12. Name William H. Miller.
13. Birthplace (City, town, or county) Unknown (State or foreign country) 1

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) Unknown. (State or foreign country)

16. (a) Informant's own signature Mamie Davis

(b) Address 3641 Cass Ave.

17. (a) Burial & Removal (Burial, cremation, or removal) (b) Date thereof 7-4-1939 (Month) (Day) (Year)

(c) Place: burial or cremation Winfield Mo

18. (a) Signature of funeral director Ricks Funeral Home.

(b) Address Winfield Mo.

19. (a) JUL 3 1939 (Date received local registrar) (b) J. F. Biedeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1 year 1939 hour 11 00 minute P. M.

21. I hereby certify that I attended the deceased from Apr. 1939 July 1st, 19 , to July 1, 1939 that I last saw him alive on June 30, 1939 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis with arteriosclerosis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations Operation for prostatic Enlarge & Kidney Hx Cutpsy	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature A. F. Hinkes (M. D. or other)

Address 4901 Easton. Date signed 7-2-39

(Licensed Embalmer's Statement on Reverse Side)

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 John Keller

Licensed Embalmer No. 3880

P. O. Address St Louis

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

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